

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS
AMENDED JULY 1, 2006

NUMBER: 11-W-00030/1

TITLE: MassHealth Medicaid Section 1115 Demonstration

AWARDEE: Massachusetts Executive Office of Health and Human Services

The following are the Special Terms and Conditions (STCs) for Massachusetts' MassHealth Section 1115(f) Medicaid Demonstration extension (hereinafter "Demonstration"). The STCs listed below will be effective for the extension commencing with Demonstration Year 9, starting July 1, 2006. The parties to this agreement are the Massachusetts Executive Office of Health and Human Services (Commonwealth) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the Commonwealth's obligations to CMS during the life of the Demonstration.

1. All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the award letter of which these terms and conditions are part, shall apply to the MassHealth program. To the extent the enforcement of such laws, regulations, and policy statements, in the absence of the MassHealth demonstration, would have affected Commonwealth spending on program components affected by the MassHealth demonstration in ways not explicitly anticipated in this agreement, CMS shall incorporate such effects into a modified budget limit for MassHealth. The modified budget limit would be effective upon enforcement of the law, regulation, or policy statement. The growth rates for the budget neutrality baseline, as described in Attachment B, are not subject to change under this STC. If any portion of the law, regulation, or policy statement cannot be linked specifically with program components that are or are not affected by the MassHealth demonstration (e.g., all disallowances involving provider taxes or donations), the effect of enforcement on the Commonwealth's budget limit of that portion of the law shall be proportional to the size of the MassHealth demonstration in comparison to its entire Medicaid program (as measured in aggregate Medical Assistance payments).

The Commonwealth shall, within the time frame specified in law, come into compliance with any changes in Federal law, regulation, and policy affecting the Medicaid program that occur after the approval date of this waiver. For the current extension period of this Demonstration, this requirement shall also apply to all applicable regulation and policy issued by CMS with respect to the Deficit Reduction Act (DRA), signed into law on February 8, 2006, including but not limited to the documentation of citizenship requirements contained in section 1903(x) of the Social Security Act (the Act). To the extent that a change in Federal law that impacts statewide section 1115 demonstrations such as MassHealth would, in the absence of the waiver, affect state Medicaid spending on

program components affected by the MassHealth demonstration, CMS shall incorporate such changes in law into a modified budget limit for MassHealth. The modified budget limit would be effective upon implementation of the change in the Federal law, as specified in law. If mandated changes in the Federal law require state legislation, the change shall take effect on the day such state legislation becomes effective, or in the absence of such legislation, on the last day such legislation was required. If any portion of the new law cannot be linked specifically with program components that are or are not affected by the MassHealth demonstration (e.g., laws affecting sources of Medicaid funding), the effect of that portion of the new law on the Commonwealth's budget limit shall be proportional to the size of the MassHealth demonstration in comparison to its entire Medicaid program (as measured in aggregate Medical Assistance payments). The Commonwealth may submit to CMS an amendment to the MassHealth program to request exemption from changes in law occurring after the approval date of this demonstration. The cost to the Federal government of such an amendment must be offset to ensure that total projected expenditures under the modified MassHealth program do not exceed projected expenditures in the absence of MassHealth (assuming full compliance with the change in law).

2. The Commonwealth shall provide CMS with information to effectively monitor the demonstration upon request.
3. The Commonwealth shall not be required to submit Title XIX state plan amendments for changes to eligibility for any populations covered solely under the demonstration through an approved expenditure authority.
4. **Amendments to the Demonstration.**
 - a) Changes related to eligibility, enrollment, benefits, delivery systems, the Insurance Partnership program, cost sharing, evaluation design, Federal financial participation, budget neutrality, the Safety Net Care Pool, the Commonwealth Care Health Insurance Program, sources of non-Federal share of funding, other comparable program elements must be submitted to CMS as amendments to the demonstration. The state shall not implement changes to these elements without prior approval by CMS. Attachment D contains all elements of the Demonstration that are subject to the amendment process. All financial reporting and budget neutrality definitions applicable to the demonstration are fully incorporated into Attachments A and B.
 - b) Amendment requests must be submitted to CMS no later than 90 days prior to the date of implementation for approval by CMS.
 - c) Amendment requests as specified above should include the following:
 - An explanation of the public process used by the Commonwealth to reach a decision regarding the requested amendment;
 - A data analysis, using the guidelines outlined in section 9 of Attachment D, which identifies the specific “with-waiver” impact of the proposed amendment on the current budget neutrality cap of the demonstration and demonstrates that the

amendment will not result in a reduction of the Commonwealth's budget neutrality cushion below zero;

- An explanation of how the amendment is consistent with the overall principles and objectives of the demonstration;
- A description of how the evaluation design will be modified to incorporate this amendment request.

5. **Compliance with Managed Care Regulations.** Managed care organization (MCO), Pre-paid inpatient health plan (PIHP), Pre-paid ambulatory health plan (PAHP), and Primary care case management (PCCM) programs must comply with the 42 CFR Part 438 starting July 1, 2005.

Encounter Data

6. Any MCOs, PIHPs or PAHPs in the demonstration shall be responsible for the collection of 100 percent encounter data and the maintenance of the data at the plan level. The Commonwealth shall, in addition, develop plans for the collection, reporting, and analysis of select encounter data from the primary care clinician (PCC) and benefits to persons who are long-term unemployed, as well as a process for the validation that each plan's encounter data are both complete and accurate for 90 percent or more of the data elements required by the Commonwealth. If the completeness and/or accuracy are less than 90 percent, the Commonwealth shall require the plan to implement a corrective action plan within 90 days to bring the accuracy to acceptable levels.
7. If the Commonwealth contracts with new plans, prior to the effective date of the contract the Commonwealth will do a validation study on the completeness and accuracy of encounter data. If the plan is a newly established MCO, PIHP, PAHP or PCCM the Commonwealth will do a validation study 6 months after the effective date of the contract. The initial validity study shall include validation through a sample of medical records of Mass Health enrollees, and accuracy.
8. The Commonwealth shall submit data to the MSIS system as is consistent with Federal law and Attachment A of this document.
9. The Commonwealth must assure that encounter data maintained at MCOs can be linked with eligibility files maintained at the Commonwealth.

Eligibility/Benefits

10. Every 6 months the Commonwealth will complete a sample of an appropriate number of cases from MassHealth enrollees, based on enrollment and approved by CMS. This procedure shall be used for all Medicaid coverage groups, including those receiving services under the demonstration and those not receiving services under the demonstration (the 65 and over population as well as those who are under 65 and institutionalized). Findings will be reviewed on a semi-annual basis for the purpose of monitoring Medicaid Eligibility Quality and Control.

Providers and Delivery Systems

11. Procurement and the subsequent final contracts developed to implement selective contracting, by the Commonwealth, with any provider group shall be subject to CMS Regional Office approval prior to implementation.
12. **Public Notice.** The Commonwealth shall publish adequate and timely notice under the Commonwealth's administrative procedure law of any program-wide changes made by the Commonwealth in the MassHealth benefit package, eligibility standards, procedures for obtaining care, or rights under the program. Whenever such program-wide changes are applied to an individual beneficiary or any action or intended action affecting an individual beneficiary is taken by the Commonwealth under existing program rules, the Commonwealth shall give individual, adequate, and timely notice to such beneficiary.

Administration/Reporting/Other

13. **Monthly Calls.** CMS shall schedule monthly conference calls with the Commonwealth. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment, cost sharing, premiums, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, the Safety Net Care Pool, MCO financial performance that is relevant to the Demonstration, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers, or State plan amendments the State is considering submitting. CMS shall update the Commonwealth on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the Demonstration. The Commonwealth and CMS shall jointly develop the agenda for the calls.
14. **Quarterly Progress Reports.** Quarterly reports will be submitted 60 days following the close of each quarter. Quarterly reports will include a discussion of events occurring during the quarter that affect health care delivery, enrollment, quality of care, access, health plan financial performance that is relevant to the Demonstration, the benefit package, the Safety Net Care Pool (SNCP), the 10 percent of the SNCP used for infrastructure and capacity building, the Title XXI Medicaid expansion population, and other operational issues. The report will also include a spreadsheet illustrating the most current “with” and “without” waiver status on both summary and detailed level through the current approval period using the most recent actual expenditures, as well as proposals for addressing any problems identified. The reports must also include the most current member month information for each Medicaid Eligibility Group (MEG). . While reports based on clinical indicators will be reported annually in Encounter Data Reports, the quarterly reports will include utilization data and a discussion of events and efforts related to the collection and verification of clinical encounter data.
15. **Quarterly Enrollment Reports for Medicaid expansion children eligible for Title XXI**

funding. Each quarter the State will provide CMS with an enrollment report by Demonstration population showing end of quarter actual and unduplicated ever-enrolled figures. Enrollment data for the Medicaid expansion children will be entered into the Statistical Enrollment Data System (SEDS) within 30 days after the end of each quarter. The Commonwealth must provide quarterly Title XXI enrollment report using Form CMS-64.21E for Medicaid expansion children. Should the State exhaust its Title XXI expenditures and opt to revert to Title XIX expenditures for its Medicaid expansion children, the State must report enrollment for this population using Form CMS-64EC.

16. Reporting Requirements for Designated Health Programs Funding.

- a) By July 31 of each year the Commonwealth will identify anticipated gross state health care spending by the health programs specified in paragraph 28. This process will involve documenting that these programs are funded with state appropriations by providing the following documentation:
 - Table of projected state fiscal year spending by approved program, including applicable department code, appropriation code, total appropriated funding and total spending projected appropriation. The state will continue to budget the gross amount for the health programs.
 - Copy of final signed state budget (General Appropriation Act) showing approved total appropriation amounts.
 - Signed certification from the Executive Office of Health and Human Services that federal funds are not included in the appropriation amount.
- b) CMS will review the list and preliminarily authorize the anticipated state/local program expenditures permitted under paragraph 28 by August 15.
- c) The Commonwealth will file a separate quarterly schedule with the CMS-64 to document actual spending made in the quarter by these programs. The Commonwealth and CMS will develop this separate schedule jointly by August 31, 2006. Notwithstanding any other term and condition, actual spending by these programs recognized under the demonstration will not exceed the amount preliminarily authorized under (b).
- d) At the end of each quarter the Commonwealth will submit to CMS a separate MMARS report for these state health programs and other service level expenditure data in a format to be determined.

17. Annual Report.

- a) The Commonwealth will submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, and policy and administrative difficulties. The Commonwealth will also submit a spreadsheet illustrating the most current “with” and “without” waiver status on both summary and detailed level through the current approval period using the most recent actual expenditures. The reports must also include the most current member month information for each Medicaid Eligibility

Group (MEG). Except for demonstration year 9 (SFY 2006), the Commonwealth will submit the annual report no later than October 1 after the end of each Demonstration year. For demonstration year 9, the draft annual report is due no later than October 31, 2006. Within 30 days of receipt of comments from CMS, a final annual report will be submitted.

- b) Beginning with the annual report for SFY 2005, the Commonwealth must include a section that details the impact the Safety Net Care Pool has on the rate of uninsurance in Massachusetts, beginning July 1, 2006.
 - c) Beginning with annual report for SFY 2006 the Commonwealth must submit an updated Exhibit A. In addition, the Commonwealth will submit a chart that details the SNCP and other Medicaid supplemental payments by BMC, CHA and UMass as well as the total for the other hospitals.
 - d) The annual report should also include a discussion of the Commonwealth's Title XXI program and its impact on the demonstration.
18. **Demonstration Evaluation.** The Commonwealth's evaluation of the MassHealth demonstration shall include a section evaluating the effectiveness of the Safety Net Care Pool and *the 40 hour work requirement for the CommonHealth working adults with disabilities*. The Commonwealth will implement the evaluation design, and submit to CMS a draft of the evaluation report 120 days prior to the expiration of this extension. CMS will provide comments within 60 days of receipt of the report. The Commonwealth shall submit the final report by September 30, 2008.
19. **Demonstration Final Report.** At the end of the demonstration, a draft final report should be submitted to CMS for comments. CMS's comments should be taken into consideration by the awardee for incorporation into the final report. The awardee should use the CMS, Office of Research and Demonstrations' Author's Guidelines: Grants and Contracts Final Reports (can be found at www.cms.hhs.gov) in the preparation of the final report. The final report is due no later than 90 days after the termination of the project.
20. **CMS Right to Suspend or Terminate.** CMS may suspend or terminate any project in whole or in part at any time before the date of expiration, whenever it determines, following a hearing that the awardee has materially failed to comply with the terms of the project. CMS will promptly notify the awardee in writing of the determination and the reasons for the suspension or termination, together with the effective date.
21. **Findings of Non-Compliance.** The Commonwealth waives none of its rights to challenge CMS's finding that the Commonwealth materially failed to comply. CMS reserves the right to withdraw waivers or costs not otherwise matchable at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest. If a waiver or costs not otherwise matchable is withdrawn, CMS will be liable for only normal close-out costs.

22. **Demonstration Phase-Out.** The Commonwealth may suspend or terminate this demonstration in whole or in part at any time before the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. If the project is terminated, or any relevant waivers suspended by the State, CMS will be liable for only normal close-out costs. Demonstration phase-out will consist of:
- a) The Commonwealth will submit a phase-out plan of the demonstration to CMS at least 6 months prior to initiating phase-out activities and, if desired by the Commonwealth, an extension plan on a timely basis to prevent disenrollment of MassHealth members if the waiver is extended by CMS. Nothing herein shall be construed as preventing the Commonwealth from submitting a phase-out plan with an implementation deadline shorter than 6 months when such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval.
 - b) During the last 6 months of the demonstration, the enrollment of individuals who would not be eligible for Medicaid under the current state plan will not be permitted unless the waiver is extended by CMS.

Enrollment Caps

23. The Commonwealth is authorized to impose enrollment caps on the demonstration populations specified below. The Commonwealth shall submit changes to these caps as an amendment to the demonstration
- a) Effective March 1, 2006, the number of adults with HIV enrolled in Family Assistance may be limited to 1,300 individuals.
 - b) Effective July 1, 2005, the number of other adults enrolled in Family Assistance may be limited to 6,000 individuals.
 - c) Effective July 27, 2006, the number of adults enrolled in the Essential Program may be limited to 60,000 individuals.

Safety Net Care Pool and Commonwealth Care Health Insurance Program (CHIP)

24. **Definitions.** The Safety Net Care Pool (SNCP) was established effective July 1, 2005 for the purpose of reducing the rate of uninsurance in the Commonwealth. It may be used for expenditures made for the provision of health care services to uninsured individuals and unreimbursed Medicaid costs, through any type of eligible health care provider, as described in Attachment E - Safety Net Care Pool Payment Methodologies or through insurance products. In addition, SNCP funding may be used for the Commonwealth Care Health Insurance Program (C-CHIP), to provide premium assistance for the purchase of private health insurance by individuals with family income at or below 300 percent of the FPL, who are not otherwise eligible under the State plan or this demonstration. Expenditures from the SNCP are subject to the budget neutrality cap.
25. **SNCP Available Funds.** SNCP payments for demonstration years 9, 10 and 11 shall be

capped. The amount of the cap for each year is equal to the SFY 2005 supplemental payments to Boston Public Health Commission (BPHC) and Cambridge Public Health Commission (CPHC) plus the annual DSH allotment previously reimbursed under the authority of the State Plan. The DSH reimbursement methodologies authorized under the State Plan expired July 1, 2005. Supplemental payments for SFY 2005 were \$770 million and DSH payments were \$574.5 million. The total allotment for the SNCP is \$1.34 billion per year.

To the extent that Federal law changes with respect to DSH payments, a corresponding adjustment will be made to the DSH portion of the SNCP.

26. **Allowable SNCP Payments.** Payments from the SNCP may include unreimbursed Medicaid costs, inpatient hospital expenditures for the uninsured/SNCP population, outpatient hospital expenditures for the uninsured/SNCP population, and other non-hospital medical service expenditures for the uninsured/SNCP population (e.g. clinic, FQHC, physician), infrastructure expenditures subject to the limitations defined in subparagraph (a) below, expenditures for designated health programs as identified and limited by STC 27(b) and expenditures for the Commonwealth Care Health Insurance Program (C-CHIP), premium assistance program developed by Massachusetts and approved by CMS.
- a) Up to 10 percent of SNCP may be used for expenditures other than payments to providers for the provision of health care services to an uninsured individual. Payments from this sub-cap must be used for improvement of the delivery of health care to uninsured/SNCP populations, such as capacity building and infrastructure. This limit does not include premium assistance payments.
 - b) No federal financial participation will be available to reimburse the Commonwealth for the purposes authorized in subparagraph (a) above until:
 - i) The Commonwealth identifies for CMS the specific activities that will be undertaken to improve the delivery of health care to the uninsured/SNCP populations.
 - ii) The infrastructure payments are incorporated into Attachment E, The SNCP Payment Methodology; and
 - iii) Exhibit A is modified to reflect the infrastructure payments.
 - c) Progress reports on these activities shall be included in the quarterly programmatic reports and annual reports required under paragraphs 14 and 17, respectively.
27. **SNCP Payment Methodologies.** The Commonwealth must make SNCP payments in accordance with subparagraphs (a) and (b) below, as well as the payment methodologies included as Attachment E.
- a) **State Fiscal Year 2006.**
 - i) For the period July 1, 2005 through June 30, 2006, payments may be made to BPHC and CPHC from the SNCP in the same manner as they have been made for

the first eight years of the demonstration. That is, payments made to BPHC and CPHC from the SNCP may continue to be funded by transfers from BPHC and CPHC and may continue to be redirected to satisfy expenditures for the uninsured/SNCP and unreimbursed Medicaid costs.

- ii) With regard to the DSH portion of the SNCP, DSH payments will continue to be funded using revenue from hospital assessments and insurer taxes, as well as state appropriations.

b) State Fiscal Year 2007.

- i) Beginning July 1, 2006, the Commonwealth must terminate the SFY 2005 financing arrangement utilizing transfers from BPHC and CPHC to access SNCP funds.
- ii) After this date, for the period of the demonstration extension ending on June 30, 2008, the Commonwealth may only receive FFP, up to an aggregate maximum of \$385 million total computable expenditures annually, for state-only expenditures for the designated health programs outlined in subparagraph (iv) below. The Commonwealth shall submit verification to CMS that the non-Federal share of these programs comes from permitted sources. The Commonwealth may only use non-Federal funds that are permissible under federal law.
- iii) Notwithstanding subparagraph (ii) above, FFP is not available for non-“DSH” SNCP payments that pay for costs associated with the provision of non-emergency care for unqualified aliens. A reduction in payments will apply to the following: payments to hospitals above the DSH amount; payments for which Federal match is drawn down based on CPE and program costs; and for state programs where the alien status of program recipients is unknown. To implement this limitation, 5.3 percent of the total unmatched amount for the designated health programs outlined in subparagraph (iv) below shall be considered expenditures for unqualified aliens in addition to other non-“DSH” payments. That percentage will be reduced from the total unmatched amount to equal the amount available for FFP.
- iv) Except for modifications of the listed expenditure amounts, any changes to the programs in the following list will require an amendment pursuant to the process outlined in paragraph 4. Modifications of the expenditure amounts for these designated health programs will be accommodated through the process outlined in paragraph 16.

Sect	Dept	State Appropriation Account Number(s)	Program Name	Program ID Number	FY07 Program Expenditure Projection	FY07 Maximum Expenditures Eligible for FFP (subject to (iii) above)
EHS	DMH	50460000 50462000 50470001 50470002 50950015	Community rehabilitative support	3059	\$ 20,743,399	\$ 20,743,399
EHS	DMH	50425000 50460000 50470001 50470002 50950015	Individual and family flexible support	3066	\$ 12,586,948	\$ 12,586,948
EHS	DMH	50460000 50470001 50470002	Day Rehabilitation	3037	\$ 8,044,961	\$ 8,044,961
EHS	DMH	50425000 50460000 50470002 50950015	Day services	3068	\$ 5,561,935	\$ 5,561,935
EHS	DMH	50460000 50470002	Adult respite care services	3048	\$ 4,774,652	\$ 4,774,652
EHS	DMH	50425000 50460000 50462000 50470001 50470002 50950015	Individual support	3056	\$ 2,854,638	\$ 2,854,638
EHS	DMH	50425000 50470001 50470002 50950015	Child/adolescent respite care services	3078	\$ 1,250,157	\$ 1,250,157
EHS	DMH	50460000	Recreational therapy services	3128	\$ 40,822	\$ 40,822
EHS	DMH	50425000 50460000 50462000 50470001 50950015	Community Mental Health Center (CMHC) continuing care (non-inpatient)	3146	\$ 3,148,091	\$ 3,148,091

Sect	Dept	State Appropriation Account Number(s)	Program Name	Program ID Number	FY07 Program Expenditure Projection	FY07 Maximum Expenditures Eligible for FFP
EHS	DMH	50425000 50460000 50470001 50950015	Comprehensive psychiatric services	3132	\$ 2,579,069	\$ 2,579,069
EHS	DMH	50425000 50460000 50462000 50950015	Homeless support services	3039	\$ 2,658,698	\$ 2,658,698
EHS	DMH	50460000	Occupational therapy services	3126	\$ 107,549	\$ 107,549
EPS	DOC	8900-0001	Department of Corrections - DPH/Shattuck Hospital Services		\$ 3,000,000	\$ 3,000,000
EHS	DPH	45131115	Multiple Sclerosis		\$ 412,368	\$ 412,368
EHS	DPH	45801000	Universal Immunization Program		\$ 34,871,508	\$ 34,871,508
EHS	DPH	45100110	Community Health Centers		\$ 5,127,016	\$ 4,610,964
EHS	DPH	45100150	CenterCare		\$ 2,654,974	\$ 2,276,454
EHS	DPH	45131002	Growth and nutrition programs		\$ 723,570	\$ 723,570
EHS	DPH	45100810	SANE program		\$ 733,409	\$ 180,000
EHS	DPH	45131114	Hepatitis C		\$ 1,000,000	\$ 1,000,000
EHS	DPH	45131112	Prostate Cancer Prevention - Screening component		\$ 1,000,000	\$ 1,000,000
EHS	DPH	45701500	Breast Cancer Prevention		\$ 7,302,368	\$ 1,000,000
EHS	DYS	42000100	Committed Non-Residential: health care staff		\$ 477,402	\$ 477,402
EHS	DYS	42000100	Committed Non-Residential: third party medical payments		\$ 83,457	\$ 83,457
EHS	EHS	40000990	Children's Medical Security Plan		\$ 12,268,567	\$ 12,268,567
EHS	ELD	91101630	Home Care Services		\$ 103,142,340	\$ 98,462,340
EHS	ELD	91101633	Home Care Case Mgmt and Admin		\$ 39,311,751	\$ 34,828,841
EHS	ELD	91101500	Enhanced Community Options (ECOP)		\$ 42,831,919	\$ 41,814,316
EHS	ELD	91101455	Prescription Advantage		\$ 44,000,000	\$ 44,000,000
EHS	ELD	91109002	Grants to Councils on Aging		\$ 7,000,000	\$ 7,000,000
EHS	MCB	41102000	Turning 22 - personal vocational adjustment		\$ 414,000	\$ 414,000
EHS	MCB	41102000	Turning 22 - respite		\$ 180,000	\$ 180,000

Sect	Dept	State Appropriation Account Number(s)	Program Name	Program ID Number	FY07 Program Expenditure Projection	FY07 Maximum Expenditures Eligible for FFP
EHS	MCB	41102000	Turning 22 – training		\$ 153,548	\$ 153,548
EHS	MCB	41102000	Turning 22 – co-op funding		\$ 119,366	\$ 119,366
EHS	MCB	41102000	Turning 22 – mobility		\$ 66,399	\$ 66,399
EHS	MCB	41102000	Turning 22 – homemaker		\$ 30,000	\$ 30,000
EHS	MCB	41102000	Turning 22 – client supplies		\$ 10,646	\$ 10,646
EHS	MCB	41102000	Turning 22 – vision aids		\$ 3,162	\$ 3,162
EHS	MCB	41102000	Turning 22 – medical evaluations		\$ 200	\$ 200
EHS	MRC	41204010	Turning 22 Services		\$ 1,065,000	\$ 1,065,000
EHS	MRC	41206000	Head Injured Programs		\$ 961,000	\$ 961,000
EHS	VET	14100400	Veterans' Benefits		\$ 4,035,524	\$ 4,035,524
EHS	DPH	45131121	Stroke Education and Public Awareness		\$ 500,000	\$ 500,000
EHS	DPH	45131122	Ovarian Cancer Screening, Education, and Prevention		\$ 100,000	\$ 100,000
EHS	DPH	45131116	Renal Disease		\$ 50,000	\$ 50,000
EHS	DPH	45160264	Diabetes Screening and Outreach		\$ 175,000	\$ 175,000
EHS	DPH	45901503	Pediatric Palliative Care		\$ 800,000	\$ 800,000
EHS	HCF	4100-1051	Fisherman's Partnership		\$ 3,000,000	\$ 3,000,000
EHS	HCF	4100-1051	Community Health Center Uncompensated Care Payments		\$ 54,963,030	\$ 54,963,030

28. **Use of Certified Public Expenditures (CPE).** The Commonwealth may use CPEs under this demonstration in accordance with the limitations described in Attachment A, paragraph 18. The Commonwealth may use intergovernmental transfers received from units of government, including governmentally operated health care providers. Units of government must have general taxing authority. In the case of a permissible intergovernmental transfer from a governmentally operated health care provider, the governmentally operated health care provider must have access to State or local tax revenues. Accessing State or local tax revenues means that the governmentally operated health care provider must either have direct taxing authority or must be able to access funding as an integral part of a governmental unit with taxing authority (that is legally obligated to fund the governmental health care provider's expense, liabilities, and deficits) so that no contractual arrangement with the State or local government is necessary in order for the health care provider to receive tax revenues
29. **Use for Institutions of Mental Disease.** The Commonwealth may use the SNCP for expenditures related to individuals residing in an Institution for Mental Disease that are not otherwise eligible for Federal financial participation under this demonstration. The

payments are conceptually consistent with section 1923(h)(2) and are operationalized in Attachment E, SNCP Payment Methodology.

Attachment A

General Financial Requirements Under Title XIX

1. **Quarterly Expenditure Reports.** The Commonwealth will provide quarterly expenditure reports using the form CMS 64 to report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in Attachment C (Monitoring Budget Neutrality).
2. **Reporting Expenditures under the Demonstration.** The following describes the reporting of expenditures under the Demonstration.
 - a) In order to track expenditures under this demonstration, Massachusetts will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. All expenditures subject to the budget neutrality cap will be reported on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10.C. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10.C., as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality cap," is defined below in paragraph 2(c). A separate accounting of SNCP payments and benefit costs must be provided to facilitate fiscal oversight.
 - b) For each demonstration year a Form CMS-64.9 Waiver and/or 64.9P Waiver will be submitted reporting expenditures subject to the budget neutrality cap. All expenditures subject to the budget neutrality ceiling for demonstration eligibles (current and expansion) and for all expenditures made under the SNCP authority will be reported by Medicaid Eligibility Group as described in paragraph 3(c). The sum of the expenditures, for all demonstration years reported during the quarter, will represent the expenditures subject to the budget neutrality cap (as defined in Attachment C).
 - c) For purposes of this section, the term "expenditures subject to the budget neutrality cap" will include all Medicaid expenditures on behalf of the demonstration participants and all expenditures made under the SNCP (as described in paragraph 5(g) of this Attachment). All expenditures for the demonstration services will be reported on the Form CMS-64.
 - d) At such time as the Commonwealth determines that it does not have sufficient Title XXI funding to cover expenditures for the optional low income children included in 1902(r)(2) children and begins claiming Title XIX funds for this population, the Commonwealth will complete for each demonstration year a Form 64.9 Waiver and/or CMS-64.9P Waiver reporting expenditures subject to the budget neutrality cap. The

Attachment A

General Financial Requirements Under Title XIX

sum of the expenditures for all demonstration years reported during the quarter, will represent the expenditures subject to the budget neutrality cap (as described in subparagraph (c) above).

- e) Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the demonstration.
- 3. **Claiming Period.** All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the Form CMS-64 in order to properly account for these expenditures in determining budget neutrality. Beginning July 1, 2005, separate waiver schedules will be completed for demonstration years 6, 7, and 8 along with those reported in demonstration year 5.
- 4. **Reporting Member Months.** The following describes member month reporting under the Demonstration.
 - a) For the purpose of calculating the budget neutrality expenditure cap described in Attachment C, the Commonwealth must provide to CMS on a quarterly basis the actual number of eligible member/months for the Medicaid Eligibility Groups as defined in Attachment C. This information shall be provided to CMS for a 2-year period after the quarter in conjunction with the quarterly progress report referred to in the Administration/Reporting/Other section of the STCs and this attachment. If a quarter overlaps the end of one demonstration year (DY) and the beginning of another, member/months pertaining to the first DY must be distinguished from those pertaining to the second. (Demonstration years are defined as the years beginning on the implementation date, or the anniversary of that day.)
 - b) The term "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member/months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member/months.
- 5. **Medicaid Eligibility Groups.** The MassHealth Medicaid eligibility groups (MEGs) consist of:
 - a) Base Families;
 - b) Base Disabled;

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- c) 1902(r)(2) children;
- d) 1902(r)(2) disabled;
- e) CommonHealth;
- f) Breast and Cervical Cancer Treatment Program (BCCTP);
- g) Family Assistance;
- h) HIV/Family Assistance;
- i) Basic;
- j) Essential;
- k) Insurance Partnership (IRP);
- l) Medical Security Plan (MSP); and
- m) Safety Net Care Pool. This MEG is created to capture the expenditures under Safety Net Care Pool (SNCP) authority granted under this extension.

6. **MassHealth Demonstration Program Eligible Members.** The groups described in paragraph 5 (a) through (l) are categorized as follows:
- a) Base families and base disabled are members who would be eligible for Medicaid under Title XIX.
 - b) 1902(r)(2) children, 1902(r)(2) disabled and BCCTP are additional members eligible under section 1902(r)(2) of the federal Social Security Act, including children through age 18 and disabled individuals. The 1902(r)(2) children MEG includes optional targeted low-income children eligible for Title XXI funding, as well as certain pregnant women; and
 - c) Expansion members are individuals solely eligible under the streamlined eligibility and expansion authorities of this demonstration and who are not eligible under Title XIX eligibility requirements.
7. **MassHealth Demonstration Program Expenditures.** The MEG described in paragraph 5(m) above includes expenditures authorized under the Safety Net Care Pool. These expenditures will include inpatient hospital expenditures for the uninsured population, outpatient hospital expenditures for the uninsured population, and other non-hospital medical service expenditures for the uninsured population (e.g. clinic, FQHC, physician), infrastructure expenditures subject to the limitations defined in Attachment C, and any expenditures related to new insurance products, including premium assistance, that may be developed by Massachusetts and approved by CMS.
8. **Base Family Category.** The “Base Family” MEG consists of the following individuals who receive MassHealth Standard coverage:
- a) All MassHealth Demonstration program-eligible individuals receiving Temporary Aid to Families with Dependent Children (TADFC);

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- b) All MassHealth Demonstration program-eligible individuals who are eligible under Title XIX as children, parents/caretaker-relatives or pregnant woman. This group includes protected active cases whose eligibility would be otherwise terminated under streamlined eligibility rules (e.g. spend-down cases). Members who meet this definition and are determined to have a disability are included in the “disabled” category.
- c) All MassHealth Demonstration program-eligible children ages 1 through 18 with gross incomes at or below 133% FPL.
- d) All MassHealth Demonstration program-eligible pregnant women and newborns (under age 1) at or below 185% FPL.
- e) MassHealth Demonstration program-eligible non-pregnant parents with gross family income at or below 133% FPL.
- f) Members who are identified as “Non-qualified Aliens”, “Protected Aliens”, or “Aliens with Special Status” if the member meets the counting convention methodology definition of a member of the base population (would have been eligible for Medicaid under the current eligibility rules), and the member utilizes emergency services (MassHealth Limited). Members who meet this definition and are determined to have a disability are included in the “disabled” category.
- g) The small group of individuals who are eligible for Medicaid under current rules were transferred to MassHealth Basic in the first year of the demonstration. These individuals are considered caretakers under current rules, but were not originally considered part of the family group under streamlined eligibility. The number of members considered part of this group will be estimated and included in the base population.
- h) “Aliens with Special Status” eligible for a state funded coverage who would have been eligible for Medicaid under the current rules. (The group of members who would have been eligible for Medicaid will be estimated, and if any of those members utilize emergency services, they will be considered base members.) Members who meet this definition and are determined to have a disability are included in the “disabled” category.
- i) Non-qualified Aliens eligible for a limited package of services (emergency services only) who would have been eligible for Medicaid under the eligibility rules in effect prior to August 22, 1996, but were not on the caseload as of the implementation date of the demonstration. Members who meet this definition and are determined to have a disability are included in the “disabled” category.

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9. **Base Disabled Category.** The “Base Disabled” MEG consists of the following individuals who receive MassHealth Standard coverage:
- a) All MassHealth Demonstration program-eligible individuals receiving Supplemental Security Income (SSI);
 - b) All MassHealth Demonstration program-eligible individuals who are eligible under Title XIX using SSI disability criteria. This group includes protected active cases whose eligibility would be otherwise terminated under streamlined eligibility rules (e.g. spend-down cases). Members who meet this definition but have not been determined to have a disability are included in the “family” category.
 - c) Certain individuals with a disability ages 18 to 64 with gross family income at or below 114% FPL.
 - d) Members who are identified as “Non-qualified Aliens”, “Protected Aliens”, or “Aliens with Special Status” if the member meets the counting convention methodology definition of a member of the base population (would have been eligible for Medicaid under the current eligibility rules), and the member utilizes emergency services (MassHealth Limited). Members who meet this definition but have not been determined to have a disability are included in the “family” category.
 - e) The small group of individuals who are eligible for Medicaid under current rules were transferred to MassHealth Basic after the first year of the demonstration. These individuals are considered caretakers under current rules, but were not originally considered part of the family group under streamlined eligibility. The number of members considered part of this group will be estimated and included in the base population. Members who meet this definition but have not been determined to have a disability are included in the “family” category.
 - f) “Aliens with Special Status” eligible for a state funded coverage who would have been eligible for Medicaid under the current rules. (The group of members who would have been eligible for Medicaid will be estimated, and if any of those members utilize emergency services, they will be considered base members.) Members who meet this definition but have not been determined to have a disability are included in the “family” category.
 - g) Non-qualified Aliens eligible for a limited package of services (emergency services only) who would have been eligible for Medicaid under the eligibility rules in effect prior to August 22, 1996, but were not on the caseload as of the implementation date of the demonstration. Members who meet this definition but have not been determined to have a disability are included in the “family” category.
 - h) Certain disabled individuals currently eligible for Medicaid under the deductible provision will become CommonHealth members with a premium payment as soon as

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they meet their deductible. This group will be estimated and considered part of the base population.

10. **The 1902(r)2 Children Category.** This MEG consists of:

- a) MassHealth Demonstration program-eligible newborns (under age 1) with gross family income between 186% FPL and 200% FPL.
- b) MassHealth Demonstration program-eligible children age 1 through 5 with gross family income between 134% FPL and 150% FPL.
- c) MassHealth Demonstration program-eligible children age 6 through 14 (date of birth on or after 9/30/83) with gross family income between 134% FPL and 150% FPL.
- d) MassHealth Demonstration program-eligible children through age 18 with gross family income between 134% FPL and 150% FPL; and
- e) MassHealth Demonstration program-eligible pregnant women with gross family income between 186% and 200% FPL.

The children identified in subparagraphs (a) through (d) are referred to as optional targeted low-income children and meet the definition specified in section 2110(b)(1) of the Act. The Commonwealth is eligible to receive Title XXI funds for expenditures for these children.

11. **The 1902(r)2 Disabled Category.** This MEG consists of MassHealth Demonstration program-eligible disabled and blind individuals ages 18 through 64 with gross family income between 115% and 133% FPL.

12. **CommonHealth Category.** This MEG consists of disabled individuals (both adults and children) who are not otherwise eligible for Standard coverage.

13. **The BCCTP Category.** This MEG consists of women with breast and cervical cancer who have been screened through a CDC program and have income at or below 250% FPL.

14. **Expansion Categories.** All members who are not considered eligible under the MEGs outlined in paragraphs 8 through 13 are included in the following MEGs:

- a) **Family Assistance:** members who receive coverage through the Family Assistance program, including children at higher incomes.
- b) **HIV/Family Assistance:** persons with HIV who receive coverage through the Family Assistance program.

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- c) **Basic:** long-term unemployed persons who are recipients of state cash benefits (Emergency Aid to Elders, Disabled and Children) or mental health services from the Department of Mental Health and receive Basic coverage
 - d) **Essential:** Long-term unemployed persons who are not eligible for Basic coverage.
 - e) **Insurance Partnership (IP):** persons eligible to receive employer subsidies through the Insurance Partnership program who are not otherwise considered eligible for any other MEG. Some IP eligible families will have children eligible under 1902(r)(2) and adults eligible under the IP provision (for example, a family with income at 140% FPL). In these cases, the family will receive a subsidy towards family coverage, the children will be counted as 1902(r)(2), and the parents will be counted as IP members. All payments made to employers as part of the MassHealth Insurance Partnership will be counted as Insurance Partnership payments.
 - f) **Medical Security Plan:** medical coverage for those receiving unemployment benefits provided by the Division of Unemployment Assistance
 - g) **Safety Net Care Pool:** payments to providers for health care services furnished to uninsured individuals and unreimbursed Medicaid costs.
 - i) No federal financial participation will be available to reimburse the Commonwealth for any payments funded directly or indirectly from the Medical Assistance Trust Fund established in M.G.L. c. 29, §2QQQ, as added by Section 8 of Chapter 58 of the Acts of 2006, until the authorizing statute for said fund is amended to remove any and all references to directing funds from public entities to the Commonwealth, refunding public funds directed to the trust fund, and intergovernmental transfers from public entities.
 - ii) No federal financial participation will be available for any payments to a governmentally operated or non-governmentally operated health care provider that are returned, refunded or otherwise redirected by such health care provider under the direction of State statute, regulation, contractual obligation or otherwise.
15. The term “demonstration eligibles” refers to persons who are eligible for the demonstration and receiving services subject to the budget neutrality cap.
16. **Populations Ineligible for the Demonstration.** An individual is considered ineligible for MassHealth Demonstration if the individual meets one or more of the following criteria:
- a) 65 years of age and older (unless a parent or caretaker relative of a child 19 years old or younger);
 - b) institutionalized;
 - c) a recipient of services under a Home and Community Based Waiver;
 - d) a member of the Program of All-Inclusive Care of the Elderly (PACE) program;
 - e) a Kaileigh Mulligan case;
 - f) a Title IV-E adoption case;

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- g) a refugee (100% federally funded); or
- h) a state-funded Department of Social Services/Department of Youth Services case.

17. **Medicaid Funding Process.** The standard Medicaid funding process will be used during the demonstration. The Commonwealth must estimate matchable Medicaid expenditures on the quarterly Form CMS-37. As a supplement to the Form CMS-37, the Commonwealth will provide updated estimates of expenditures subject to the budget neutrality cap as defined in paragraph 2(c) of this Attachment. The CMS will make Federal funds available based upon the Commonwealth's estimate, as approved by CMS. Within 30 days after the end of each quarter, the Commonwealth must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 quarterly with Federal funding previously made available to the Commonwealth for the quarter, and include the reconciling adjustment in the finalization of the grant award to the State.
18. **Certified Public Expenditures.** The standard Medicaid funding process will be used during the demonstration. The Commonwealth must estimate matchable Medicaid expenditures on the quarterly Form CMS-37. As a supplement to the Form CMS-37, the Commonwealth will provide updated estimates of expenditures subject to the budget neutrality cap as defined in 2.d. of this Attachment. The CMS will make Federal funds available based upon the Commonwealth's estimate, as approved by CMS. Within 30 days after the end of each quarter, the Commonwealth must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 quarterly with Federal funding previously made available to the Commonwealth for the quarter, and include the reconciling adjustment in the finalization of the grant award to the State.

With regard to certified public expenditures (CPEs) under the demonstration, only units of government, including governmentally operated health care providers, can certify that non-federal public funds have been expended to satisfy total costs eligible for Federal matching funds under Medicaid. However, the sources of non-Federal funds utilized shall not include impermissible provider taxes and donations as defined under section 1903(w) of the Social Security Act.

Health care providers that are non-governmentally operated may participate in the use of CPEs in conjunction with a unit of government. The unit of government must certify the amount of state or local tax dollars appropriated to the non-governmentally operated health care provider. The non-governmentally operated health care provider receiving the appropriation can participate in CPEs by demonstrating, through a CMS approved cost reporting mechanism, the costs eligible under Title XIX that have been satisfied by the state or local appropriation. No Federal financial participation is available for any otherwise eligible Title XIX costs that exceed the amount of appropriation from the state or local unit of government to the non-governmentally operated health care provider.

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For purposes of governmentally operated and non-governmentally operated hospitals, such costs are identifiable under the Medicare/Medicaid cost report (CMS-2552). Specifically, the costs related to the provision of inpatient hospital and outpatient hospital services to Medicaid and uninsured patients are reflected in the CMS-2552. To the extent the Commonwealth desires to utilize the CPE mechanism for services not reflected on the CMS-2552, CMS must approve the cost reporting vehicle for which the Commonwealth would certify such costs as eligible for FFP, prior to Federal matching of any such costs.

In order to transition to a CPE funding process, the Commonwealth is required to use the latest settled CMS-2552 or any other CMS-approved cost reporting vehicle for each governmentally operated hospital as a vehicle to estimate allowable costs for the current spending year. These estimates can be trended forward using a standard health care-related inflationary factor, as approved by CMS, to the current spending year. The Commonwealth must reconcile the estimated costs to the actual costs using the CMS-2552 or any other CMS-approved cost reporting vehicle. At that time, the Commonwealth would revise its FFP claim to reconcile to actual allowable costs under Medicaid.

The Commonwealth shall submit for CMS approval a document that articulates the methodology it will use to determine those costs eligible for federal matching through CPEs under the Safety Net Care Pool. The CPE methodology will be completed by the Commonwealth and approved by CMS prior to the Commonwealth claiming any federal matching funds associated with such certified public expenditures.

19. **Extent of Federal Financial Participation.** Subject to CMS approval of the source of non-federal share of funding, CMS will provide FFP at the applicable Federal matching rate for the following, subject to the limits described in Attachment C:
 - a) Administrative costs associated with the direct administration of MassHealth at the appropriate FFP rate authorized under Medicaid.
 - b) Net expenditures and prior period adjustments of the Medicaid and MassHealth programs which are paid in accordance with the approved State plan. CMS will provide FFP for medical assistance payments with dates of service and during the operation of the 1115 demonstration.
 - c) At the enhanced Federal match rate (75%), for costs related to the performance of annual independent, external reviews of the quality of services furnished by MCOs and PIHPs conducted by organizations which meet the requirements of 42 CFR 438 Subpart E.
 - d) FFP will be phased down for expenditures for services to a MassHealth enrollee ages 21 through 64 residing in an Institution for Mental Disease for the first 30 days of an inpatient episode, subject to an aggregate annual limit of 60 days. The expenditures allowable for FFP will be the percentage of aggregate expenditures for such services set forth below for the relevant time period:

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General Financial Requirements Under Title XIX

Period	Allowable Portion of Expenditures
July 1, 2005-June 30, 2006	100%
July 1, 2006-June 30, 2007	50%
July 1, 2007-June 30, 2008	0%

- e) Employee subsidies as follows:
 - i) The entire employee subsidy portion of the IP, subsidized by the Commonwealth, provided that the employer or self-employed person contributes at least 50 percent of the cost of health insurance benefits, which must meet the basic benefit level, as defined by the Commonwealth, and that the gross income of the employee's family is no more than 200 percent of FPL.
 - ii) Effective October 1, 2006, the gross income of the employee's family may be no more than 300 percent of FPL in order to secure the subsidy described in subparagraph (e)(i). Further, this subsidy is limited to the value of the individual subsidy that would be paid under the Commonwealth Care Health Insurance Program.
- f) Employer subsidies as follows:
 - i) The employer subsidy portion, subsidized by the Commonwealth, of the IP for the amount of subsidy granted for "new employer-provided health insurance". "New employer-provided health insurance" is defined as 1) contributions of at least 50 percent of the cost of health insurance by employers who have made no contribution to the cost of employees' insurance during any part of the 12 months previous to the implementation of IP, and 2) contributions of at least 50 percent of the cost of health insurance made to a class of employees by any employers who, during the 12 months previous to implementation of the IP, had made no contribution to the health insurance for those employees currently in that class (where definition of class of employees, such as part-time employees, is subject to CMS approval, and where such class has contained employees during the 12 months previous to the implementation of the IP). CMS will not match employer subsidies paid by the Commonwealth except as provided above.
 - ii) Effective July 1, 2007, self-employed individuals or sole proprietors are not eligible for the employer subsidy described in subparagraph (f)(i).
- g) Net expenditures associated with the Safety Net Care Pool described in paragraph 26 of the STCs, subject to the restrictions outlined in paragraphs 28 and 29 of the STCs and must be consistent with the payment methodologies outlined in Attachment E.
 - i) All payments from the SNCP must be made in accordance with Attachment E and the sources and uses of funds in Exhibit A as updated through the annual report.

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General Financial Requirements Under Title XIX

Any changes to the payment methodology must be submitted as an amendment pursuant to paragraph 4.

- h) The annual financial statements of public hospitals, which incur CPEs eligible for FFP, shall be reviewed annually and the results made available to CMS. Audit documentation should indicate the amount and designation of State and local appropriations provided to the hospital, specifying amounts designated to cover costs eligible for FFP as unreimbursed CPE. Audit documentation should include the methodologies employed by hospitals to identify patient insurance status, enrollment in MassHealth, and the cost of services provided.
 - i) Expenditures for women with breast or cervical cancer described in the BCCTP category, at the enhanced Federal Medical Assistance Percentage (which is equivalent to the State's SCHIP match rate) available under the authority of the Breast and Cervical Cancer Prevention and Treatment Act.
20. The Commonwealth will make available for review all records that were used in the preparation and submission of the CMS 64 and CMS 37 reports.
21. **Insurance Partnership Definitions.**
- a) "Continuing employer-provided health insurance" is defined as a contribution of at least 50 percent of the cost of health insurance by employers who have made the same contribution during the twelve months prior to the implementation of the IP, toward health insurance which met and meets the basic benefit level (BBL). This also applies to the self-employed period. Employer subsidies for continuing employer-provided health insurance will be State-financed.
 - b) "Improved employer-provided health insurance" is defined as 1) contributions of at least 50 percent of the cost of health insurance by employers who have made a contribution of less than 50 percent during any part of the 12 months previous to the implementation of IP, and 2) contributions of at least 50% of the cost of health insurance made by employers who, had offered health insurance which did not meet the BBL. Employer subsidies for improved employer-provided health insurance will be State-financed.
 - c) Health insurance (individual, two-person, or family) purchased by a self-employed person on his/her own behalf, will be treated as employer-provided insurance, and will be eligible for employer subsidies and employee subsidies which, for FFP purposes, will be subject to the same definitions as above. For the purpose of making this determination, one-half of the cost of health insurance purchased by the self-employed or sole proprietor will be eligible for an employer subsidy and one-half will be eligible for an employee subsidy. Effective July 1, 2007, a self-employed individual or sole proprietor may only be eligible for employee subsidies as specified in paragraph 19.

Attachment A

General Financial Requirements Under Title XIX

22. **Insurance Partnership Claiming.** In order to claim the MassHealth match for an employer subsidy, the Commonwealth must show that the employer met all requirements to receive a federally matchable employer subsidy. Specifically, CMS must have authority to verify such data, based upon documentation described below, as the salary of the employee who is covered, the level of coverage taken (single, two person, and three or more persons), whether the employer contributes at least 50 percent of the cost of the premium, whether coverage is obtained, whether the employee's coverage qualifies as "new employer-provided health insurance", and whether the health insurance package meets the basic level, as defined by the Commonwealth. Appropriate documentation for all MassHealth matchable subsidies must be accessible, at the offices of the appropriate Commonwealth agencies, for review and audit by CMS or its designated agent.
23. **Estate Recovery.** The Commonwealth will recover from the estates of MassHealth Standard, Family Assistance, Basic, Essential, CommonHealth, Limited, and Prenatal members all benefits that would be recoverable under state and federal statutes and regulations had the member received traditional (i.e., non-demonstration) Medicaid assistance.
24. **Liens.** The Commonwealth will follow the same practices regarding placement of liens against real estate owned by MassHealth Standard, Family Assistance, Basic, Essential, CommonHealth, Limited, and Prenatal members, as it does when real estate is owned by members receiving traditional (i.e., non-demonstration) Medicaid assistance.
25. **Third Party Recoveries.** Where a third party is making payment as a result of an accident, illness or other incident, and the Commonwealth has provided benefits under its MassHealth Standard, Family Assistance, Basic, Essential, CommonHealth, Limited, and Prenatal plans, the Commonwealth will follow the same federal and state laws and regulations, as they currently exist and as they may be amended, regarding accident/trauma recovery that apply when assistance has been provided under its traditional (i.e., non-demonstration) Medicaid program.
26. **Drug Rebates.** The Commonwealth will collect such rebates from drug manufacturers for drugs dispensed to members enrolled in MassHealth Standard, CommonHealth, Basic, Family Assistance and the Medical Security Plan Direct coverage program. The amount of such rebates the Commonwealth receives will be considered a reduction in the amount expended for the purposes of federal reimbursement (if the member's original service was federally reimbursable).

Attachment B

General Financial Requirements Under Title XXI

1. **Quarterly Expenditure Reports.** The State shall provide quarterly expenditure reports using the Form CMS-64.21U Waiver and/or CMS64.21UP Waiver to report expenditures for services through the Massachusetts Demonstration under section 1115 authority.
2. **Reporting Expenditures under the Demonstration.** In order to track expenditures under this demonstration, the State will report demonstration expenditures associated with the Medicaid Expansion children through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), as part of the routine quarterly CMS-64 reporting process. These Title XXI demonstration expenditures will be reported on separate Forms CMS-64.21U waiver and/or CMS-64.21UP waiver, identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made).
3. **Claiming Period.** All claims for expenditures related to the demonstration (including any cost settlements) must be made within two years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the appropriate waiver forms.
4. **SCHIP Funding Process.** The standard SCHIP funding process will be used during the demonstration. Massachusetts must estimate matchable SCHIP expenditures on the quarterly Form CMS-21B. On a separate CMS 21B, the State shall provide updated estimates of expenditures for the waiver population. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-21 quarterly SCHIP expenditure report. CMS will reconcile expenditures reported on the Form CMS-21 with Federal funding previously made available to the State, and including the reconciling adjustment in the finalization of the grant award to the State.
5. **Certification of Funding.** The State will certify State/local monies used as matching funds for the demonstration and will further certify that such funds will not be used as matching funds for any other federal grant or contract, except as permitted by federal law.
6. **Extent of Federal Financial Participation.** Massachusetts will be subject to a limit on the amount of Federal title XXI funding that the State may receive on demonstration expenditures during the demonstration period.
 - a) Federal title XXI funding available for demonstration expenditures is limited to the State's available allotment and any reallocated funds. Should the State expend its available allotment and reallocation, no further enhanced Federal matching funds will be available for costs of the demonstration populations until the next allotment becomes

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General Financial Requirements Under Title XXI

available. Title XIX federal matching funds will be provided if the title XXI allotment and redistribution are exhausted; however, Title XXI funds must first be used to fully fund the costs associated with the Medicaid expansion population (optional targeted low-income children included in the 1902(r)(2) MEG). Demonstration expenditures are limited to the remaining funds.

- b) If title XXI allocations are expended and the State chooses to draw down regular title XIX matching funds for the Medicaid expansion children included in this 1115 demonstration authority, the section 1115 budget neutrality cap specified in the Terms and Conditions for demonstration No. 11-W-00030/1 entitled "MassHealth Section 1115 Demonstration" shall apply. In order to provide for a seamless continuation of 1115 waiver authority for this population under Title XIX, the Commonwealth should provide CMS with adequate notification if its projections indicate that it may exceed its Title XXI allotment.

Attachment C

Monitoring Budget Neutrality

1. **Determination of Budget Neutrality.** The following describes the method by which budget neutrality will be assured under the MassHealth demonstration extension. In general, this demonstration uses a per capita cost method, and demonstration budget targets are set on a yearly basis, with a cumulative 11-year budget limit. Massachusetts will be at risk for the per capita cost (as determined by the method described below) for current eligibles, but not at risk for the number of current eligibles. By providing Federal Financial Participation for all current eligibles (including 1902(r)(2) eligibles), Massachusetts will not be at risk for changing economic conditions. However, by placing Massachusetts at risk for the per capita costs for current eligibles, CMS assures that the federal demonstration expenditures do not exceed the level of expenditures had there been no demonstration.
2. **Annual Expenditure Target.** Each yearly expenditure target for MassHealth is the sum of two budget components: (A) the projected costs of the benefit services by specified Medicaid eligibility groups (MEGs); and (B) the projected Disproportionate Share Hospital (DSH) expenditures. Each of these components has a distinct method for projecting costs into the future.
 - a) Benefit service projections for the first 5 years were for Families, Disabled, Massachusetts Commission for the Blind (MCB), and the 1902(r)(2) expansion MEGs.
 - b) Benefit service projections for the 6 extension years are for Families, Disabled, and 1902(r)(2) expansion MEGs; the MCB MEG is subsumed into the Disabled MEG. A base has been determined for each, on an accrual date of service basis, which has been projected in the future on a yearly basis. The base amounts and subsequent annual target amounts will be subject to adjustment if inaccuracies are subsequently identified as a result of Commonwealth or Federal reviews and audits.
 - c) The initial benefit base is the Commonwealth's Fiscal Year (SFY) 1994 period. The DSH base was the lower of actual expenditures or \$594.5 million, which was the Commonwealth's estimate of its final FFY 95 allotment.
 - d) Starting in SFY 2006, actual expenditures for CommonHealth MEG will be included in the expenditure limit for the Commonwealth. The amount of actual expenditures to be included will be the lower of the trended baseline CommonHealth costs, using recent base year experience and approved trend rates, or actual CommonHealth PMPM cost experience from demonstration years 09, 10, and 11. This adjustment recognizes the uniqueness of this longstanding Commonwealth program, its National contribution as a model program for legislation and health coverage programs for children and working individuals with disabilities.

The total expenditure limit over the 11-year demonstration will be the sum of the annual expenditure targets of the two components.

Attachment C

Monitoring Budget Neutrality

Projected Expenditures for Benefit Services

3. Initial 5-year Demonstration Period MEGs.

- a) The Families, Disabled, MCB, and 1902(r)(2) MEGs base year per capita costs for actual allowable benefit services, determined on an accrual date of service basis, was calculated by dividing the SFY 1994 Medicaid benefit expenditures (less excluded expenses and DSH), for each MEG, by SFY 1994 average monthly eligibles in the corresponding MEG. At the time, all current Medicaid eligibles were included in the base year calculation except for the aged. Also included in calculating the service payment ceiling were appropriate categorical eligible months.
- b) The Commonwealth estimated the 1994 baseline for the 1902(r)(2) eligibles, which included disabled persons eligible as a result of expanding income from 114 percent of FPL to 133 percent, using the same methodology as in the MassHealth proposal since claims experience did not exist for this group. The baseline was to be adjusted to reflect actual experience if expenditures for the 1902(r)(2) eligibles in the first year of the demonstration were more than 10 percent above or below the baseline.
- c) For the 1902(r)(2) MEG of Breast and Cervical Cancer Treatment Program (BCCTP), the Commonwealth estimated a baseline per capita cost consisting of the weighted average PMPM for SFY 1998-1999 for existing MassHealth enrollees with breast and cervical cancer, net of any applicable premiums and cost sharing under the demonstration
- d) Once the base year per capita costs for each category were determined, each would be projected forward by the corresponding growth rate listed below. The annual expenditure target for Medicaid benefit expenditures in a given year is the sum across MEGs of: the product of the projected per capita cost for a MEG for that year multiplied by the number of MEG eligibles, including eligibles counted as categorical according to the counting conventions agreement, where the method for counting eligibles, including any factoring of the duration of eligibility, is consistent with the counting method used in the calculation of base year per capita costs and MassHealth capitation payments.

4. Initial 5-year Demonstration Period Growth Rates. The specific growth rates for the per capita costs for each year of the first 5 years of the demonstration are listed below.

Federal Fiscal Year	Growth Factor by MEG			
	<u>Families</u>	<u>Disabled</u>	<u>MCB</u>	<u>1902(r)(2)</u>
1995	5.90%	3.46%	3.46%	2.30%
1996	7.71%	5.83%	5.83%	4.40%
1997	7.71%	5.83%	5.83%	4.80%
1998	7.71%	5.83%	5.83%	5.50%
1999	7.71%	5.83%	5.83%	5.30%
2000	7.71%	5.83%	5.83%	5.70%

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Since the above rates are based on Federal fiscal years, weighting adjustments were to be applied to align the FFY rates with the waiver years (WY). For example, using the 1902(r)(2) MEG, if the first waiver year runs from January 1, 1996 through December 31, 1996 the following adjustment was made:

$$\begin{array}{lcl} \text{FFY 1996: } 4.40\% \text{ times } 75\% & = & 3.30\% \\ \text{FFY 1997: } 4.80\% \text{ times } 25\% & = & \underline{1.20\%} \\ \text{WY 1996 rate} & & 4.50\% \end{array}$$

The growth rates for waiver year 2000 are the FFY 2000 rates.

5. **Demonstration Extension Period MEGs and Growth Rates.** For each of the 3-year extension periods, the growth rates are as listed below. The growth rates are based on waiver years, which correspond to the state's fiscal year.
- a) The MCB MEG from the first 5 years of the demonstration is subsumed into the Disabled MEG.
 - b) For the 1902(r)(2) MEG, the Disabled growth rate shall apply to disabled and BCCTP 1902(r)(2) eligibles, and the Families growth rate shall apply to the non-disabled 1902(r)(2) eligibles.
 - c) The Commonwealth shall retroactively adjust the BCCTP MEG annual per capita costs for SFY 2003 through SFY 2008 to reflect actual experience if expenditures for the 1902(r)(2) BCCTP eligibles are more than 10 percent above or below the baseline calculated by the growth rates listed below. As the historic data on the BCCTP MEG is limited, this term permits adjustments that should minimize the financial risk to the Commonwealth while avoiding the accrual of budget neutrality "savings" from the addition of this population.

State Fiscal Year	Growth Factor by MEG			
	<u>Families</u>	<u>Disabled</u>	<u>Non-Disabled 1902(r)(2)</u>	<u>Disabled 1902(r)(2) and BCCTP</u>
2003	7.71%	10.00%	7.71%	10.00%
2004	7.71%	10.00%	7.71%	10.00%
2005	7.71%	10.00%	7.71%	10.00%
2006	7.30%	7.00%	7.30%	7.00%
2007	7.30%	7.00%	7.30%	7.00%
2008	7.30%	7.00%	7.30%	7.00%

6. **Total Expenditure Limit for Expenditures Included in the Ceiling.**

- a) The total expenditure limit over the 11-year demonstration period will be the sum of the

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annual expenditure targets described above. Actual expenditures will be reported on the CMS 64 forms that the Commonwealth must submit.

- b) The Commonwealth's expenditures must not exceed the budget neutrality test; that is, the Commonwealth's total expenditures for all 11 years of the demonstration may not exceed the sum over the 11-year demonstration period of actual allowable expenditures, calculated on an accrual date of service basis, of the following two components: a) yearly per capita expenditures for benefit services (less excluded services defined below, and SNCP) and b) the yearly SNCP expenditure limits.
 - c) During the demonstration, claims for FFP will be made through the regular Medicaid reporting process, using the standard CMS 64 forms. If at the end of the demonstration period the budget neutrality provision has been exceeded, the excess Federal funds will be returned to CMS. No new limit is placed on the FFP that the Commonwealth can claim for expenditures in program categories listed under paragraph 7 below.
 - d) If the demonstration is terminated prior to the 11-year period, the budget neutrality test will be based on the time period through the termination date. Extension of the waiver beyond an 11-year operational period will not affect enforcement of budget neutrality as described above.
7. **Expenditures Excluded From Ceiling Tests.** Regular FMAP will continue for costs not subject to budget neutrality ceiling tests. Those exclusions include:
- a) Expenditures made on behalf of enrollees age 65 years of age and above and expenditures made on behalf of an enrollee under age 65 who is institutionalized (i.e., in a nursing facility) or is enrolled in a home and community based services waiver;
 - b) All Long Term Care expenditures;
 - c) Expenditures for covered services currently provided to Medicaid recipients by other state agencies or cities and towns, whether or not these services are currently claimed for federal reimbursement; and
 - d) Allowable administrative expenditures.
8. **Expenditure Review.** MassHealth expenditures will be tracked on an accrual basis. CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, no later than 6 months after the end of an individual waiver year, the Commonwealth will calculate annual expenditure targets (using actual categorical eligibles, including eligibles counted as categorical eligibles according to the counting convention agreement) for the completed year for each of the two components (benefits, and SNCP). The annual component targets will be summed to calculate a target annual spending limit. This amount should be compared with the actual claimed FFP for Medicaid. Using the schedule below as a guide, if the Commonwealth exceeds these targets they shall submit a

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corrective action plan to CMS for approval.

- Year 1 target spending limit	+8 percent
- Year 1 to 2 combined target spending limit	+6 percent
- Year 1 to 3 combined target spending limit	+4 percent
- Year 1 to 4 combined target spending limit	+2 percent
- Year 1 to 5 combined target spending limit	+0 percent
- Year 1 to 6 combined target spending limit	+3 percent
- Year 1 to 7 combined target spending limit	+1 percent
- Year 1 to 8 combined target spending limit	+0 percent
- Year 1 to 9 combined target spending limit	+3 percent
- Year 1 to 10 combined target spending limit	+1 percent
- Year 1 to 11 combined target spending limit	+0 percent

9. **Corrective Action Plan.** Should the corrective action plan result in limiting enrollment into MassHealth, entrance into programs providing health insurance for the neediest should be preserved as much as possible. The following programs and Safety Net Care Pool payments will be protected, in terms of declining order of importance:
- a) the traditional Medicaid programs (MCO, PCCP, and FFS)
 - b) CommonHealth
 - c) Family Assistance for children
 - d) HIV Family Assistance
 - e) MassHealth Program for the long-term unemployed
 - f) Employee premium under the IP
 - g) Employer subsidy for "new employer-provided health insurance" under the IP
 - h) Commonwealth Care Health Insurance program
 - i) Medical Security Program
 - j) IMD Safety Net Care Pool payments
 - k) Supplemental rate or Safety Net Care Pool payments to governmentally operated or non-governmentally operated hospitals
 - l) Safety Net Health System Payments (Section 122 of Chapter 58)

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MassHealth Program Specifications

1.0 Introduction

On April 12, 1994, the Commonwealth of Massachusetts Division of Medical Assistance (the predecessor to the Commonwealth of Massachusetts Executive Office of Health and Human Services, Office of Medicaid) submitted a request to the U.S. Department of Health and Human Services for approval of MassHealth, a five-year Medicaid Research and Demonstration Waiver under Section 1115 of the Social Security Act. The Health Care Financing Administration (HCFA), the predecessor to the Centers for Medicare and Medicaid Services (CMS), approved the waiver request on April 24, 1995, subject to a set of special terms and conditions establishing the nature, character, and extent of Federal involvement in the demonstration.

State law enabling implementation of the MassHealth demonstration was enacted in July 1996, as Chapter 203 of the Acts and Resolves of 1996 *An Act Providing Improved Access to Health Care*.

All MassHealth managed care programs incorporated into the Commonwealth's 1915(b) demonstration were incorporated into and subsumed under the MassHealth demonstration.

Implementation of the demonstration began July 1, 1997.

Pursuant to Special Term and Condition #4, Attachment C details the policy and program specifications applicable to the MassHealth Demonstration Project that were agreed to by the Massachusetts Executive Office of Human Services (EOHHS) and the Centers for Medicare and Medicaid Services (CMS) in the 1115(f) renewal of the Demonstration effective July 1, 2005.

Attachment C is arranged in sections, as follows:

Section 1	Introduction
Section 2	Eligibility
Section 3	Description of MassHealth Covered Services and Delivery Systems
Section 4	Member Enrollment
Section 5	[reserved]
Section 6	Quality Assurance
Section 7	[reserved]
Section 8	[reserved]
Section 9	Requirements for Budget Neutrality Reporting to CMS
Section 10	Administrative Confirmations
Section 11	Insurance Partnership Program

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2.0 Eligibility

This chapter describes the rules and processes that will be used in determining the eligibility of MassHealth members. The material in this chapter addresses eligibility-related issues.

Eligibility will be effective ten (10) calendar days prior to the EOHHS's receipt of an application if certain conditions are met, except for MassHealth Basic, MassHealth Essential, MassHealth Buy-in, and premium assistance payments under the Family Assistance Plan.

Eligibility requirements for MassHealth Standard are expanded by offering coverage to children through the age of 18 and increasing the financial eligibility standards for pregnant women and newborns to 200% FPL and for children, aged one through 18, to 150% FPL, and parents and disabled adults to 133% FPL. In addition, certain women with breast or cervical cancer are also eligible for MassHealth Standard.

Children whose family's self-declared income meets the Standard income requirements will be determined presumptively eligible for Standard. Uninsured children with self-declared family income between 150-200% FPL will be determined presumptively eligible for Family Assistance.

Family Assistance offers coverage to children through either the purchase of medical benefits for uninsured children or through premium assistance for children who have, or have access to, health insurance.

Adults without dependent children who are employed by a small business employer and have income equal to or under 200% FPL are also eligible for premium assistance through the Insurance Partnership (IP) program. Effective October 1, 2006, eligibility for the IP will expand to include members with gross family income at or below 300% of the FPL.

MassHealth Family Assistance is available to persons with HIV disease whose family income is at or below 200% FPL. Individuals who do not have employer sponsored health insurance will be offered coverage through the purchase of medical benefits while those who have or choose to enroll in employer sponsored health insurance will be provided premium assistance.

MassHealth Basic and Essential are available to certain long-term unemployed adults to 100% FPL.

Under CommonHealth, MassHealth has retained a modified spenddown approach (referred to here as a deductible), which is a one-time spenddown rule for that portion of the non-working disabled population (i.e. SSI-related) with incomes over 133% FPL. This rule is described in **Section 2.1.4.9**.

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MassHealth may limit the number of adults (age 19 and over) who can be enrolled in MassHealth Family Assistance, and Essential. MassHealth will impose such a limit if it determines that it does not have sufficient appropriations remaining in a fiscal year to cover its expenditures. When MassHealth imposes such a limit, no new adult applicants will be added to these coverage types, and current adult members in these coverage types who lose eligibility for any reason will not be allowed to reenroll until MassHealth is able to reopen enrollment for adults in these coverage types.

Applicants, who cannot be enrolled for the reason detailed above, will be placed on a waiting list when their eligibility has been determined. When MassHealth is able to open enrollment for adult applicants, the applications will be processed in the order they were placed on the waiting list.

2.1 Description of Eligibles

This section describes the eligibility requirements that must be met to receive medical benefits under MassHealth. These requirements include:

- Universal eligibility requirements that are common to all members, (e.g., residence) (**Section 2.1.1**);
- Citizenship and immigration requirements (**Section 2.1.2**);
- Eligibility requirements by coverage type (**Section 2.1.3**); and
- Calculation of financial eligibility (**Section 2.1.4**).

2.1.1 Universal Eligibility Requirements

All Mass Health applicants and members must meet the following requirements (Sections 2.1.1.1 through 2.1.1.6) as a condition of eligibility.

2.1.1.1 Residence Requirements

As a condition of eligibility an applicant or member must:

- Live in the Commonwealth, with the intent to remain permanently or for an indefinite period, but is not required to maintain a permanent residence or fixed address; or
- Live in the commonwealth at the time of application having entered the Commonwealth with a job commitment, whether or not currently employed, (also applicable to migrant or seasonal workers.)

Examples of applicants or members who generally do not meet the residency requirement for MassHealth are:

- Students under age 19 whose parents reside out of state; and

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- Individuals who came to Massachusetts for the purpose of receiving medical care in a setting other than a nursing facility, and who maintain a residence outside of Massachusetts.

Applicants and members who are residents of non-acute medical institutions and whose placement is expected to last at least 30 days may not have eligibility for MassHealth determined under the rules of this chapter. Eligibility for these individuals must be determined under the provisions of Title XIX.

2.1.1.1.1 Individuals in Penal Institutions

Inmates of penal institutions may not receive MassHealth benefits except under one of the following conditions, if they are otherwise eligible for MassHealth:

- They are inpatients in a medical facility; or
- They are residing outside of the penal institution and are not returning to the institution for overnight stays.

2.1.1.2 Social Security Number (SSN) Requirements

As a condition of eligibility for any MassHealth coverage type with the exception of MassHealth Limited, applicants and members must furnish an SSN. Applicants who do not have an SSN will be notified of their obligation to apply for one.

MassHealth shall verify each applicant's SSN by a computer match with the Social Security Administration.

2.1.1.2.1 Right to Know Uses of Social Security Numbers

All household members will be given written notice in a booklet accompanying their MassHealth Benefit Request of the following:

- The reason the SSNs are requested;
- The computer-matching with SSNs in other personal data files within MassHealth, other government agencies, and elsewhere; and
- That failure to provide the SSN of any person receiving or applying for benefits may result in denial or termination of his or her benefits.

2.1.1.3 Utilization of Potential Health Insurance Benefits

MassHealth pays for medical benefits only when no other source of payment is available. Applicants and members are required, as a condition of eligibility to obtain or maintain health insurance when MassHealth determines it is cost effective to do so. Members of Standard or CommonHealth may participate in MassHealth Standard/CommonHealth Premium Assistance (MSCPA), where MassHealth purchases cost-effective private health

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insurance on behalf of the member and the member receives wrap services from MassHealth. MSCPA participants are not required to contribute more towards the cost of their health insurance than they would pay without access to health insurance. MassHealth Standard and CommonHealth members who do not obtain or maintain available health insurance will be denied MassHealth benefits or lose MassHealth eligibility for all of those in the family group, unless the individual is under age 19 or pregnant.

Standard and CommonHealth members described in Sections 2.1.3.1.2.1.3.1.1, 2.1.3.1.4.1, 2.1.3.1.4.2, 2.1.3.1.6 if over age 18, 2.1.3.3., 2.1.3.3.1, and 2.1.3.3.2, who are otherwise eligible may receive fee for service benefits during a 60-day period while MassHealth investigates if they have or have access to cost-effective private health insurance that meets the basic benefit level (BBL). If MassHealth determines the private health insurance available to the member does not meet the requirements for MSCPA, the member is notified in writing and will continue receiving MassHealth Standard or CommonHealth benefits, but not necessarily on a fee for service basis. MassHealth does not consider insurance available to the member if he or she is unable to enroll due to open-enrollment periods for a private health insurance plan that is not subject to Massachusetts Law. If it is verified that the available private health insurance is cost effective, the members will be required to obtain and maintain the insurance and will receive premium subsidies and a wrap benefit. The member may receive an additional time-limited 60-day fee for service benefit while he or she enrolls in the private health insurance. If the member fails to enroll or to maintain the insurance at the end of the second 60-day period, the member will lose MassHealth benefits, unless he or she is under age 19 or pregnant.

Family Assistance members described in **Sections 2.1.3.4.6.1 and 2.1.3.4.6.2** who have or have access to private health insurance which meets the Basic Benefit Level generally will be required to obtain or maintain that insurance and are eligible to receive a premium assistance payment from MassHealth. They will not be provided any wrap services. Families with dependent children will be required to contribute to the cost of the health insurance premium if their family group gross income is greater than 150% of the FPL. MassHealth will also pay co-payments and deductibles in certain circumstances.

Adults without dependent children whose family group gross income is less than or equal to 200% of the FPL (effective October 1, 2006, less than or equal to 300% of the FPL) will be required to contribute to the cost of the health insurance premium if their family group gross income is greater than 100% FPL.

2.1.1.4 Assignment of Rights to Medical Support and Third Party Payments

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Every legally able applicant or member must assign to MassHealth his or her own rights to medical support and third party payments for medical services provided under MassHealth as well as the rights of those for whom he or she can legally assign medical support and third party payments.

The applicant or member must provide MassHealth with information to help pursue any medical support and source of third party payment, including support available from the absent parent, who is legally obligated to pay for care and services for the applicant/member and/or for person(s) on whose behalf benefits are requested unless he or she can show good cause not to provide this information.

2.1.1.5 Good Cause for Noncooperation

Good cause for non-cooperation in complying with **Section 2.1.1.4** is present if at least one of the following circumstances exists regarding the child of the applicant or member:

- The child was conceived as a result of incest or forcible rape;
- Legal proceedings for adoption are pending before a court;
- A public agency or licensed facility is assisting in resolving the issue of adoption and discussions have not lasted longer than three (3) months; or
- Cooperation would result in serious harm or emotional impairment to the child or relative with whom the child resides or to the applicant or member.

2.1.1.6 Assignment for Third Party Recoveries

As a condition of eligibility, an applicant or member must inform MassHealth when a household member is involved in an accident, or suffers from an illness or injury, which has or may result in a lawsuit or insurance claim. The applicant or member must;

- File a claim for compensation;
- Assign to MassHealth the right to recover, as allowable, an amount equal to the MassHealth benefits provided from either the member or the third party;
- Provide information about the third party claim and cooperate with MassHealth's Post Payment Recovery Unit unless MassHealth determines that cooperation would not be in the best interests of, or would result in serious harm or emotional impairment to the applicant or member.

2.1.2 Citizenship and Immigration Requirements

In determining eligibility, MassHealth evaluates the individual's citizenship/immigration status. In making this evaluation, individuals are determined to be citizens; qualified aliens; aliens meeting specific criteria and referred to as aliens with special status; protected aliens; and nonqualified aliens.

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Those aliens whom MassHealth has defined as protected aliens and aliens with special status always receive services (except for emergency services) at full state cost. All services and benefits to aliens that are provided at full state cost are not part of this demonstration,

But information pertaining to these services and benefits is included herein only to provide a comprehensive overview. These state-funded services and benefits are subject to changes of state law and regulations, and such changes may be implemented without amendment of the MassHealth 1115 Demonstration Project.

The charts provided in **Attachment 2.4** summarize by coverage type and funding source, citizenship/immigration requirements, categorical requirements the corresponding MMIS category of assistance, income standards, and service delivery mechanism. The MMIS category designates whether or not an individual's services are federally reimbursable. The following sections describe requirements for an individual to be defined as a citizen, qualified alien, alien with special status, protected alien, or nonqualified alien. The term "qualified alien" is defined here for MassHealth purposes and is not identical to the definition of "qualified alien" in 8U.S.C.164(b). However, federally reimbursable benefits provided under MassHealth are in compliance with federal law.

2.1.2.1

Citizen

A citizen of the United States is:

- An individual born in the United States or its territories, including Puerto Rico, Guam, and the U.S. Virgin Islands;
- An individual born of a parent who is a U.S. citizen; or
- A naturalized citizen

2.1.2.1.1

Qualified Aliens

The following persons, for the purpose of MassHealth eligibility, are considered qualified aliens:

- a) Persons granted asylum under section 208 of the Immigration and Nationality Act (INA);
- b) Refugees admitted under section 207 of the INA;
- c) Persons whose deportation has been withheld under section 243(h) or 241(b)(3) of the INA, as provided by s5562 of the federal Balanced Budget Act of 1997;
- d) Veterans of the United States Armed Forces with an honorable discharge not related to their alien status;
- e) Filipino war veterans who fought under U.S. command during WWII;
- f) Hmong and Highland Lao veterans who are admitted for legal permanent residence (LPR) and who fought under U.S. command during the Vietnam war;

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- g) persons with alien status on active duty in the U.S. Armed forces, other than active duty for training;
- h) The spouse, unremarried surviving spouse, or unmarried dependent children of the alien described in (a) through (d);
- i) aliens or their unmarried dependent children, as defined in federal law, who have been subjected to battery or extreme cruelty by their spouse, parent, sponsor, or a member of their household, and who no longer reside in the same household as the batterer;
- j) persons who entered as Cuban/Haitian entrants under section 501(e) of the Refugee Education Assistance Act of 1980;
- k) Native Americans with at least 50 percent American Indian blood who were born in Canada pursuant to section 289 of the INA or other tribal members born in territories outside of the U.S. pursuant to 25 USC450 (b)(e);
- l) Amerasians admitted pursuant to section 584 of Public Law 100-202; Persons admitted for legal permanent resident (LPR) under the INA; Persons granted parole for at least one year under section 212(d)(5) of the INA; and
- m) Conditional entrants under section 203(a)(7) of the INA as in effect prior to April 1, 1980.

These optional aliens (items k – m above), if they arrived prior to 8/22/96, or if they arrived later and have had their status for five or more years, will be provided federally reimbursable benefits, if otherwise eligible. This time limitation will not apply if they are also qualified under one of the preceding categories (first eight bullets above).

2.1.2.1.2

Aliens with Special Status

Persons described in the bullets below who entered the United States on or after 8/22/96 and have not had their status for five or more year are referred to as “aliens with special status” provided they are not also described in the first eight bullets of **section 2.1.2.1.2**

Persons admitted for legal permanent residence (LPR) under the INA;
Persons granted parole for at least one year under section 212(d)(5) of the INA; and
Conditional entrants under section 203(a)(7) of the INA as in effect prior to April 1, 1980.

In addition, persons permanently residing in the United States under color of law (PRUCOLS) as described in 42 CFR 435,408(b)(3) through (b)(7), (b)(10) through (b)(14), and (b)(16) are also referred to as aliens with special status.

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Benefits provided to aliens with special status shall, except for MassHealth Limited, be provided at full state cost.

2.1.2.1.3

Protected Aliens

Persons who were receiving medical assistance or CommonHealth on the date of the demonstration's implementation and who meet one of the following immigration statuses, shall be considered protected aliens:

Aliens with Special Status (legal permanent residents, parolees, and conditional entrants) entering the United States on or after 8/22/96; and Aliens whose immigration status met medical assistance eligibility requirements prior to July 1, 1997, and who are not considered qualified aliens. These include persons permanently residing in the United States under color of law.

2.1.2.1.4

Nonqualified Aliens

Any alien not defined as a qualified alien, an alien with special status, or a protected alien.

2.1.2.1.5

Verification of Immigration Status

For aliens, a determination of eligibility will be made once the application is complete except for documentation of immigration status. Aliens who have not submitted documentation of immigration status within sixty (60) days of the date of the eligibility determination, or whose verification cannot be confirmed by the U.S. Immigration and Naturalization Service; shall subsequently;

- Be eligible only for MassHealth Limited if otherwise eligible for MassHealth Standard except for women described in **Section 2.1.3.1.7**; or
- Be ineligible for any MassHealth benefit if not otherwise eligible for MassHealth Standard.

2.1.3

Eligibility Requirements by Coverage Type

There are seven MassHealth Coverage Types:

- MassHealth Standard for children, families, pregnant women, disabled individuals and certain women with breast or cervical cancer;
- Prenatal for pregnant women;
- CommonHealth for disabled adults and disabled children who are not eligible for Standard;
- Family Assistance for children and for aliens with special status who are under age 19 who are not eligible for Standard or CommonHealth, adults who have

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employer-sponsored health insurance available through a qualified employer; and persons with HIV disease;

- Basic for persons receiving Emergency Aid to Elders, Disabled and Children (EAEDC) and certain Department of Mental Health (DMH) clients who are long-term or chronically unemployed;
- Essential for the long-term or chronically unemployed who do not meet the eligibility criteria for Basic; and
- Limited for nonqualified aliens, (undocumented aliens, aliens with special status, and protected aliens) if they would be eligible for Standard but for their immigration status except for nonqualified aliens with breast or cervical cancer as described in **Section 2.1.3.1.7**.

For each coverage type, this document will describe categorical requirements and financial standards for MassHealth.

2.1.3.1 MassHealth Standard

This section contains the categorical requirements and financial standards for MassHealth Standard serving families, children under 19, pregnant women, disabled individuals and certain women with breast or cervical cancer.

MassHealth will claim enhanced federal reimbursement under Title XXI for some individuals described in this section provided they are uninsured, under the age of 19, and meet other criteria described in Title XXI. These include children described in **Sections 2.1.3.1.2.1, 2.1.3.1.2.2, and 2.1.3.1.2.3**; parents under 19 described in **Section 2.1.3.1.4**; and pregnant women under 19 described in **Section 2.1.3.1.5**.

2.1.3.1.1 Extended Eligibility

2.1.3.1.1.1 Extended Eligibility When Cash Assistance Terminates

Members of a family group whose cash assistance terminates will continue to receive four months of MassHealth Standard coverage. This coverage will begin in the month the family group became ineligible provided they are terminated from EAEDC or TAFDC and are determined to be potentially eligible for MassHealth or terminated from TAFDC because of receipt of or an increase in spousal or child support payments.

Members of a family group who become ineligible for TAFDC for employment-related reasons continue to receive MassHealth for a full 12-calendar month period beginning with the date on which they became ineligible for TAFDC, provided:

- the family group continues to include a child who is under age 19,

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or if he or she has reached age 19, is expected to complete his or her secondary level studies before his or her 20th birthday; and

- a parent or caretaker relative continues to be employed.

Some family groups who receive MassHealth Standard when cash assistance ends had income at or below 133 percent of the federal-poverty level during their extended period. If during the extended period that family group has increased earnings that raise the family group's gross income above that limit, the family group is eligible for another full 12-calendar month period that begins with the date on which the increase occurred, provided:

- the family group continues to include a child who is under age 19; and
- a parent or caretaker relative continues to be employed.

2.1.3.1.1.2

Extended Eligibility When Earned Income Increases above 133% FPL

Members of a family group who receive MassHealth Standard (whether or not they receive TAFDC) and have increased earnings that raise the family group's gross income above 133 percent of the federal-poverty level will continue to receive MassHealth Standard. This coverage will begin with the date on which the increase income occurred and continue for a full 12-calendar month period, provided:

- the family group continues to include a child who is under age 19; and
- a parent or caretaker relative continues to be employed.

2.1.3.1.1.3

Redetermination of Eligibility at End of Extended Period

MassHealth reviews the continued eligibility of the family group at the end of the extended period described in **2.1.3.1.1.1** and **2.1.3.1.1.2**.

2.1.3.1.2

Eligibility Requirements for Children Under Age 19

Children under the age of 19 may establish eligibility for Standard Coverage subject to the requirements below.

2.1.3.1.2.1

Children Under Aged One

Eligibility of a child under age one (1) is established under the following condition:

- Eligibility for a child under age (1) born to a woman who was not receiving MassHealth Standard on the date of the child's birth is

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established if the gross income of the family group is less than or equal to 200% of the federal poverty level (FPL); or

- Eligibility for a child born to a woman who was receiving MassHealth Standard or MassHealth Limited on the date of the child's birth is automatic for one (1) year provided the child continues to live with the mother.
- A MassHealth Standard eligible child who is receiving inpatient hospital services on the date of his or her first birthday shall remain eligible until the end of the stay for which the inpatient services are furnished.

Children Aged One through 18

Eligibility of a child aged 1 through 18 is established if the gross income of the family group is less than or equal to 150% of the FPL.

A MassHealth eligible child who is receiving inpatient hospital services on the date of his or her 19th birthday shall remain eligible until the end of the stay for which the inpatient services are furnished.

Presumptive Eligibility for Standard

A child shall be determined presumptively eligible for Standard based on the family group's self declaration of gross income on the Medical Benefit Request (MBR), if that income meets the financial requirements of MassHealth Standard described in Section 2.1.3.

Presumptive eligibility begins 10 calendar days prior to the date the MBR is received at the MEC and lasts until MassHealth makes an eligibility determination. If information necessary to make the eligibility determination is not submitted within 60 days of the begin date, the MBR will be deactivated and presumptive eligibility will end. A child may receive presumptive eligibility only once in a twelve-month period.

Reserved

Eligibility Requirements for Parents and Caretaker Relatives

2.1.3.1.4.1 Eligibility Requirements for Parents

A natural, step or adoptive parent shall be eligible for Standard coverage provided:

- The gross income of the family group is less than or equal to 133% of the FPL; and
- The parent resides with his or her children or has children who are absent from

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home to attend school.

2.1.3.1.4.2 Eligibility Requirements for Caretaker Relatives

A caretaker relative shall be eligible for Standard coverage provided:

- The caretaker relative chooses to be part of the family group;
- The gross income of the family group is less than or equal to 133% of the FPL; and
- The caretaker relative lives with children to whom he or she is related by blood, adoption or marriage, or is a spouse or former spouse of one of those relative provided neither parent lives in the home.

Eligibility Requirements for Pregnant Women

A pregnant woman whose gross family group income is less than or equal to 200% of the FPL is eligible for Standard Coverage. In determining the family group size, the unborn child or children are counted as if born and living with the mother.

Eligibility, once established, shall continue for the duration of the pregnancy and for the two- (2) calendar months following the month in which the pregnancy ends regardless of any subsequent changes in family group income.

Disabled Individuals

Extended MassHealth Eligibility When SSI Benefits End

Any disabled persons whose SSI-Disability benefits have been terminated shall continue to receive MassHealth coverage until MassHealth makes a determination of ineligibility.

Disabled Individuals

Disabled individuals may establish eligibility for Standard coverage if;

- They are permanently and totally disabled
- The family group gross income is less than or equal to 133% of FPL

Disability Determination

Disability shall be established by one of the following:

Certification of legal blindness from MCB;

A determination of disability by the Social Security Administration; or

- A determination of disability by MassHealth's Disability Evaluation service.

Medicare Premium Payment

For MassHealth Standard members described in section **2.1.3.1.6.1.1** who are also eligible for Medicare, MassHealth will (1) pay the cost of the monthly Medicare Part B premiums, (2) hospital insurance under Medicare Part A; and, (3) the cost

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of deductibles and co-insurance under Medicare Part A and B. Coverage shall begin on the first day of the month following the date of the MassHealth eligibility determination.

Eligibility Requirements for Women with Breast or Cervical Cancer

A woman with breast or cervical cancer shall be eligible for Standard coverage provided she:

- Is under the age of 65;
- Is uninsured;
- Is not otherwise eligible for Standard;
- Has family income at or below 250% of the FPL (as determined by the Department of Public Health [DPH] on behalf of MassHealth;
- Was screened through the Center for Disease Control's (CDC's) National Breast and Cervical Cancer Early Detection Program (administered in Massachusetts by the DPH's Women's Health Network) and found to be in need of cancer treatment services (including precancerous conditions).

MassHealth will receive 65% FFP for women described at Section 2.1.3.1.6 who have breast or cervical cancer with the following exception. MassHealth will receive only 50% FFP for women who are eligible for this benefit and also appear to be otherwise eligible for Standard as a person under 19, a parent, pregnant woman, or disabled person. MassHealth will receive this lower level of FFP until such time as it is able to make a final eligibility determination under these provisions

Standard Premium

Adults and children age 6 and older (with the exception of individuals described in section **2.1.3.1.1.2**) who meet the requirements described above may be assessed a monthly (health insurance) premium in accordance with the provisions of section **2.1.4.10**.

Medical Coverage Date

The begin date of medical coverage for MassHealth Standard shall be ten (10) calendar days prior to the date a Medical Benefit Request (MBR) is received at any MassHealth Enrollment Center (MEC) or outreach site, provided all required verifications with the exception of documentation of immigration status have been submitted within 60 calendar days of the information request.

If required verifications are received after the sixty (60) day period, the begin date of medical coverage shall be ten (10) calendar days prior to the date on which the verifications were received, provided such verifications are received with one (1) year of receipt of the MBR.

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MassHealth Prenatal

This section contains the categorical requirements and financial standards for Prenatal Coverage.

MassHealth will claim enhanced federal reimbursement under Title XXI for some of the individuals covered under the section provided they are uninsured, under the age of 19, and meet other criteria described in Title XXI.

2.1.3.2.1 Eligibility Requirements

A pregnant woman whose self declared family group gross income is less than or equal to 200% of the FPL shall be eligible for Prenatal coverage.

2.1.3.2.2 Medical Coverage Date

Presumptive eligibility begins 10 calendar days prior to the date the MBR is received at any MEC or MassHealth outreach site and lasts until MassHealth makes an eligibility determination. If information necessary to make the eligibility determination is not submitted with 60 days of the begin date, the MBR will be deactivated and presumptive eligibility will end.

2.1.3.3 MassHealth CommonHealth

This section contains the categorical requirements and financial standards for CommonHealth coverage available to disabled children, disabled adults and disabled working adults. The requirements differ depending on whether or not the disabled adult is considered working.

Generally, MassHealth treats 18 year olds as children when making eligibility determinations. However, in determining whether a person who is 18 is disabled for purposes of eligibility for CommonHealth, MassHealth follows the disability requirements of Title XVI, which treats 18 years olds as adults.

MassHealth will claim enhanced federal reimbursement for disabled individuals described in this section provided they are uninsured, under the age of 19, and meet other criteria described in Title XXI. Children under age 19 who are aliens with special status and who are otherwise eligible will receive CommonHealth at full state cost. (For immigrant children who are also eligible for Limited, federal reimbursement is provided for emergency services only).

2.1.3.3.1 Disabled Working Adults

Disabled working adults must meet the following requirements:

- Be age 19 to 64 (inclusive);
- Be employed at least forty (40) hours per month; or if employed less than forty (40) hours per month have been employed at least 240 hours in the six- (6) month period immediately preceding the month of application;

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- Be permanently and totally disabled except for the requirement of not being engaged in substantial gainful activity as determined by MassHealth's disability evaluation service; and
- Be ineligible for MassHealth Standard.
- CommonHealth members who terminate their employment shall continue to be eligible for CommonHealth for up to three calendar months after termination of their earned income provided they continue to make timely payment of monthly premiums.

2.1.3.3.2 Disabled Adults (Non-working)

Disabled adults must meet the following requirements:

Be age 19 to 64 (inclusive);

- Not be employed or, if employed, not engaged in substantial gainful activity as determined by MassHealth's disability determination service;
- Be permanently and totally disabled;
- Be ineligible for MassHealth Standard; and
- Meet a one-time only deductible (spenddown) in accordance with **Sections 2.1.4.8 and 2.1.4.9.**

2.1.3.3.3 Disabled Children

Disabled children under age 18 must meet the following requirements:

- Be totally and permanently disabled; and
- Be ineligible for MassHealth Standard;

Disabled 18 year olds must meet the following requirements:

- Be ineligible for MassHealth Standard; and
- If not working, be permanently and totally disabled based on the disability criteria for adults and 18 year olds, as described in Attachment 1.2; or
- If working, be permanently and totally disabled based on the disability criteria for adults and 18 year-olds, as described in attachment 1.2 (except for engagement in substantial gainful activity).

2.1.3.3.4 Disabled Aliens with Special Status

Children under the age of 19 who are aliens with special status, as described in **Section 2.1.2.1.3**, may be eligible for CommonHealth provided they meet all of the requirements of **Section 2.1.3.3.3**. They may also be eligible for CommonHealth if they meet the requirements for MassHealth Standard at **Section 2.1.3.1.6.1.1** but for their immigration status.

2.1.3.3.5 Determination of Disability

Disability shall be established by one of the following:

- Certification of legal blindness from MCB; or

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- A determination of disability by the Social Security Administration; or
- A determination of disability by MassHealth's disability evaluation service.

2.1.3.3.6 CommonHealth Premium

Disabled adults and disabled children who meet the requirements described above may be assessed a monthly (health insurance) premium in accordance with the provisions of **Section 2.1.4.10**.

2.1.3.3.7 Medical Coverage Date

- The begin date of medical coverage for CommonHealth for all children (age 18 and under), and for adults (age 19 and over) shall be ten (10) calendar days prior to the date a Medical Benefit Request (MBR) is received at any MassHealth Enrollment Center or outreach site, provided all required verifications with the exception of documentation of immigration status have been submitted within sixty (60) calendar days of the date of the information request. If required verifications are received after the sixty (60) calendar day period, the begin date of medical coverage shall be ten (10) calendar days prior to the date on which the verifications were received, provided such verifications are received within one (1) year of receipt of the MBR.

2.1.3.4 MassHealth Family Assistance

This section contains the categorical requirements and financial standards for MassHealth Family Assistance. This coverage type provides coverage either through the purchase of medical benefits or through premium assistance payment.

2.1.3.4.1 Eligibility Requirements for the Purchase of Medical Benefits

MassHealth will claim enhanced federal reimbursement under Title XXI for the children described in this section who were uninsured at the time of application, with the exception of aliens with special status (described in **Section 2.1.3.4.1.1**, **2.1.3.4.1.2**, and **2.1.3.4.1.3**) who will receive these services at full state cost.

2.1.3.4.1.1 Children Under the Age of 19

Children under the age of 19, including aliens with special status as described in Section 2.1.2.1.3, may establish eligibility for the purchase of medical benefits provided:

- The gross income of the family group is between 150% and 200% FPL;
- The child is ineligible for MassHealth Standard and MassHealth CommonHealth;
- and
- The child does not have or have access to health insurance.

2.1.3.4.1.2 Persons with HIV Disease

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Persons with HIV disease may establish eligibility for the purchase of medical benefits provided they:

- Are under the age of 65 (unless the person is an alien with special status, in which case the person must be under the age of 19);
- Have family group gross income that is less than or equal to 200% FPL;
- Are ineligible for MassHealth Standard or MassHealth CommonHealth; and
- Do not have employer-sponsored health insurance or choose not to accept employer sponsored insurance.

2.1.3.4.1.3 Medicare Premium Payment

MassHealth will pay the cost of the monthly Medicare Part B premiums for MassHealth Family Assistance members described in **Section 2.1.3.4.1.2**, who are also eligible for Medicare. Payment will begin in the calendar month following MassHealth's eligibility determination.

2.1.3.4.2 Family Assistance Premium

Individuals who meet the requirements in **Section 2.1.3.4.1.1** or **2.1.3.4.1.2** may be assessed a monthly health insurance premium in accordance with the provisions of **Section 2.1.4. 10**.

2.1.3.4.3 Presumptive Eligibility for Family Assistance

An uninsured child whose self-declared family group income is greater than 150% FPL and less than or equal to 200% FPL shall be determined presumptively eligible for Family Assistance. Presumptively eligible children shall not be assessed a monthly health insurance premium. A child may only be presumptively eligible for Family Assistance if the applicant states he or she has no health insurance coverage.

Presumptive eligibility begins 10 calendar days prior to the date the MBR is received at the MEC and lasts until MassHealth makes an eligibility determination. If information necessary to make the eligibility determination is not submitted within 60 days of the begin date, the MBR will be deactivated and presumptive eligibility will end. A child may receive presumptive eligibility only once in a twelve-month period.

2.1.3.4.5 Medical Coverage Date

The begin date of medical coverage for all children (ages 18 and under), and for adults (ages 19 and over) who have not been placed on a waiting list pursuant to Section 2.0 of this Chapter, for the purchase of medical benefits under MassHealth Family Assistance shall be ten (10) calendar days prior to the date a Medical Benefit Request (MBR) is received at any MassHealth Enrollment Center (MEC) or outreach site, provided all required verifications with the exception of documentation of immigration status and/or verification of HIV status have been submitted within sixty (60) calendar days of the date of the information request. If required verifications are received after the sixty (60) calendar day period, the begin date of medical coverage shall be ten (10) calendar days prior to the date on which the

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verifications were received, provided such verifications are received within one (1) year of receipt of the MBR.

The begin date of medical coverage for MassHealth Family Assistance applicants enrolled from the waiting list will be the date the application was processed from the waiting list.

2.1.3.4.5.1 Verification of HIV Disease

For persons who indicate on the MBR that they have HIV disease, a determination of eligibility will be made once family group income has been verified. Persons who have not submitted verification of HIV diagnosis within sixty days of the eligibility determination shall subsequently have their eligibility redetermined as if they did not have the HIV disease.

2.1.3.4.6 Eligibility Requirements for Premium Assistance

Premium assistance subsidizes payment of the member's health insurance premium in accordance with the formula and process described in **Section 3.6**, for members described in **Sections 2.1.3.4.6.1** and **2.1.3.4.6.2**. MassHealth will provide premium assistance equal to the policy holder's total premium, less the applicable MassHealth premium as described in **Section 2.1.4.10** for families whose family group gross income is less than or equal to 150% FPL; for adults with family group gross income less than or equal to 100% FPL; and for aliens with special status under the age of 19, as described in **Section 2.1.3.4.6.1**.

Persons with HIV disease described in **Section 2.1.3.4.6.3** may also receive premium assistance. MassHealth will provide premium assistance equal to the policy holder's total premium, less the applicable MassHealth premium as described in **Section 2.1.4.10** to members with family group gross income less than or equal to 200% FPL.

MassHealth will claim enhanced federal reimbursement under Title XXI for some of the children described in **Section 2.1.3.4.6.1**, provided they were uninsured at the time of application for MassHealth and meet other criteria described in Title XXI.

The premium assistance payment is described in **Section 3.6**.

2.1.3.4.6.1 Families with Children Under Age 19

Children under the age of 19, including aliens with special status as described in **Section 2.1.2.1.3**, may be eligible for premium assistance payments provided they have, or have access to, employer sponsored health insurance that meets the Basic Benefit Level as described in **Section 3.6**, and meet the following additional requirements;

- The family group gross income is between 150% and 200% FPL;
- The child is ineligible for MassHealth Standard or CommonHealth; and

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- The child is enrolled in, and retains coverage under, the employer sponsored health insurance plan, (NOTE; the employer does not need to be a qualified employer for the child to be eligible under this section. For example, the employer may be a large employer or a non-participating small employer).
- MassHealth will also pay certain co-payments and deductibles for the children described in this Section provided they:
- are citizens or qualified aliens as described in **Sections 2.1.2.1.1 and 2.1.2.1.2;**
- were uninsured at the time of application, and enrolled in employer-sponsored health insurance due to MassHealth action; and
- are not employed by the Commonwealth of Massachusetts.

MassHealth payment is limited to co-payments and deductibles incurred by eligible children for well child visits as well as any other co-payments and deductibles incurred in a 12 month period that exceed five percent of the family's gross annual income.

2.1.3.4.6.2 Adults

Adults who are under age 65 may establish eligibility for premium assistance provided:

- The family group gross income is less than or equal to 200% of the FPL (Effective October 1, 2006, eligibility for the IP will expand to include members with gross family income at or below 300% of the FPL.);
- The adult is not eligible for MassHealth Standard or CommonHealth;
- The individual is employed by a small business employer who meets the requirements of **Section 2.1.3.4.7;** and
- The individual enrolls in, and retains coverage under, the employer's health insurance plan.

Individuals whose spouse and/or noncustodial children are receiving MassHealth must enroll in a health plan that provides coverage to the dependents provided MassHealth determines it is cost effective to do so and the employer contributes at least 50% of the premium cost.

The employer must also be a qualified employer as described in **Section 2.1.3.4.8.**

2.1.3.4.6.3 Persons With HIV Disease

Persons with HIV disease may establish eligibility for premium assistance provided they:

- Are under the age of 65;

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- Have family group gross income that is less than or equal to 200% FPL;
- Are ineligible for MassHealth Standard or CommonHealth; and
- either have or have available employer-sponsored health insurance in which they choose to participate.

MassHealth will also pay for all services covered under the purchase of medical benefits that are not covered by the individual's employer-sponsored health insurance.

Persons eligible under this section who also meet the requirements of **Sections 2.1.3.4.6.1** or 2.1.3.4.6.2 will receive premium assistance under the provisions of this section.

2.1.3.4.7 Small Employer

An employer will be considered a small employer if it meets the following requirements;

- Has 50 or fewer full-time employees;
- Offers health insurance to its employees that meets the basic benefit level;
- Contributes at least 50% of the cost of the employee's health insurance premium.

2.1.3.4.8 Qualified Employer

An employer who meets all of the requirements of a small employer shall be considered qualified if the employer;

- Purchases health insurance through a billing and enrollment intermediary (BEI) or directly through an insurance company; and
- Has completed an Insurance Partnership Employer application and been approved by MassHealth as a qualified employer.

MassHealth will make insurance partnership payments as described in **Section 11.5** to qualified employers.

2.1.3.4.9 Access to Employer Sponsored Health Insurance

MassHealth may waive its requirement for children described in **Section 2.1.3.4.6.1**, to access employer sponsored health insurance if MassHealth determines it is more cost effective to purchase medical benefits under MassHealth Family Assistance than to assist the family with payments of health insurance premiums.

2.1.3.4.10 Eligibility Date

Once MassHealth has determined eligibility, premium assistance payments shall begin in the month of the MassHealth eligibility determination or the month in which the insurance deduction begins, whichever is later. Premium assistance payments are for the following month's coverage.

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Persons described in Section 2.1.3.4.6.3 shall also be eligible for services provided under the purchase of medical benefits that are not covered by the individual's employer sponsored health insurance. The medical coverage date for these services shall be established in accordance with Section 2.1.3.4.5.

2.1.3.5 MassHealth Basic

This section contains the categorical requirements and financial standards for MassHealth Basic. This coverage type is available to individuals or members of a couple, who are under the age of 65, who either receive EAEDC cash assistance or who are eligible to receive services from the Department of Mental Health (DMH) and are long-term or chronically unemployed. MassHealth Basic coverage is available either through the purchase of medical benefits or through premium assistance payments.

2.1.3.5.1 Purchase of Medical Benefits for Basic Members Defined

The purchase of medical benefits under MassHealth Basic is available to unemployed adults aged 19 through 64 who:

- do not have, or have access to, health insurance, including health insurance offered by the college or university that they attend; or
- have health insurance that MassHealth has determined does not cover the applicant's chronic medical condition requiring frequent treatment and medical services, or is of significant cost to the applicant.

2.1.3.5.2 Premium Assistance for Basic Members

Premium assistance under MassHealth Basic is available to unemployed adults aged 19 through 64 who have health insurance that:

- MassHealth has determined covers the applicant's chronic medical condition requiring frequent treatment and medical services and for which they must pay a premium;
- is not of significant cost to the applicant;
- is not available from the college or university that they attend; and
- meets the MassHealth cost effective analysis

2.1.3.5.3 Eligibility Requirements for the Purchase of Medical Benefits

2.1.3.5.3.1 Long-term Unemployed DMH Clients

Individuals and members of a couple, who are under age 65 are eligible for the purchase of medical benefits provided they have no health insurance as defined in **Section 2.1.3.5.1** and they:

- Are not eligible for unemployment compensation;

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- Have been unemployed for more than one year; or during the past twelve months have earned less than the minimum amount of earnings necessary to qualify for Unemployment Compensation;
- Have been identified by the Department of Mental Health (DMH) as getting services or as being on a waiting list to get services from the DMH;
- Have gross income less than or equal to 100% of the FPL;
- Are not eligible for MassHealth Standard or CommonHealth

A member of a couple who is under age 65 is eligible for the purchase of medical benefits provided he or she meets the above requirements and his or her spouse is not employed more than 100 hours per month or the spouse is not eligible for premium assistance payments as described in **Section 2.1.3.4.6.2**.

2.1.3.5.3.2 EAEDC Recipients

Individuals and members of a couple, who receive EAEDC cash assistance are eligible for the purchase of medical benefits provided they have no health insurance and are not otherwise eligible for MassHealth Standard.

Generally, this population is comprised of chronically unemployed, disabled adults aged 19 through 64 who are pending an eligibility determination from SSI or whose disability does not meet the SSI criteria. The EAEDC cash payment provides income of approximately 50% of the federal poverty level.

2.1.3.5.3.3 Extended Eligibility When EAEDC Terminates

Individuals or members of a couple whose EAEDC terminates and who are determined to be potentially eligible for MassHealth shall continue to receive medical benefits under MassHealth Basic until MassHealth makes an eligibility determination.

2.1.3.5.3.4 Extended Coverage for the Purchase of Medical Benefits

Members who would have become ineligible for Basic coverage due to employment shall continue to receive medical benefits under MassHealth Basic for up to six calendar months after their date of employment provided health insurance is not available (i.e. not offered or subject to a waiting period) to them from their employer or their spouse's employer.

2.1.3.5.3.5 Medical Coverage Date

Persons who meet the requirements of this section shall have medical coverage established as of the date of enrollment in a MassHealth contracted health plan.

2.1.3.5.4 Premium Assistance

Premium assistance is available to persons who would be eligible for Basic coverage as defined in **Section 2.1.3.5.3.1**, but have health insurance. Premium assistance is limited to payment of all or part of the person's health insurance premium.

2.1.3.5.4.1 Eligibility Date

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Once MassHealth has determined eligibility, premium assistance shall be effective on the first day of the calendar month following MassHealth's receipt of the member's health insurance information.

2.1.3.5.4.2 Extended Eligibility for Premium Assistance

Persons who become ineligible for premium assistance due to earning will continue to have all or part of their premiums paid for a six calendar month period following their date of employment provided neither they nor their spouse are eligible for premium assistance payments as described in **Section 2.1.3.4.6.2**.

2.1.3.6 MassHealth Essential

This section contains the categorical requirements and financial standards for MassHealth Essential. This coverage type is available to individuals or members of a couple, who are under the age of 65 who are long-term or chronically unemployed and do not meet the eligibility criteria for MassHealth Basic. MassHealth Essential coverage is available either through the purchase of medical benefits or through premium assistance payments.

2.1.3.6.1 Purchase of Medical Benefits for Essential Members Defined

The purchase of medical benefits under MassHealth Essential is available to unemployed adults aged 19 through 64 who:

- do not have, or have access to, health insurance, including health insurance offered by the college or university that they attend; or
- have health insurance that MassHealth has determined does not cover the applicant's chronic medical condition requiring frequent treatment and medical services, or is of significant cost to the applicant.

2.1.3.6.2 Premium Assistance for Essential Members

Premium assistance under MassHealth Essential is available to unemployed adults aged 19 through 64 who have health insurance that:

- has determined covers the applicant's chronic medical condition requiring frequent treatment and medical services and for which they must pay a premium;
- is not of significant cost to the applicant;
- is not available from the college or university that they attend; and
- meets the MassHealth cost effective analysis

2.1.3.6.3 Eligibility Requirements for the Purchase of Medical Benefits

Individuals and couples under age 65 are eligible for Essential Coverage provided they are uninsured as described in **Section 2.1.3.6.1** and:

- are not eligible for unemployment compensation;

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- have been unemployed for more than one year, or during the past twelve months have earned less than the minimum amount of earnings necessary to qualify for unemployment compensation;
- have gross income less than or equal to 100% of the FPL; and
- are not eligible for MassHealth Standard, CommonHealth, Family Assistance, or Basic.
- A member of a couple who is under age 65 is eligible for Essential coverage provided her or she meets the above requirements and his or her spouse is not employed more than 100 hours per month or the spouse is not eligible for premium assistance payments as described in **Section 2.1.3.4.6.2**

2.1.3.6.3.1 Medical Coverage Date

Persons who meet the requirements of this section shall have medical coverage established as of the date of enrollment in a MassHealth contracted Primary Care Clinician (PCC) Plan.

2.1.3.6.4 Eligibility Requirements for Premium Assistance

Premium Assistance is available to persons who would be eligible for Essential coverage as defined in **Section 2.1.3.6.3**, but have health insurance as described at **Section 2.1.3.6.2**. Premium Assistance is limited to payment of all or part of the person's health insurance premium.

2.1.3.6.4.1 Eligibility Date

Once MassHealth has determined eligibility, premium assistance shall be effective on the first day of the calendar month following MassHealth's receipt of the member's health insurance information.

2.1.3.6.5 Enrollment Cap

MassHealth, at its discretion, shall freeze enrollment upon determination that further enrollment of MassHealth Essential members would result in expenditures in excess of allotted funding.

2.1.3.7 MassHealth Limited

This section contains the eligibility requirements for MassHealth Limited. This coverage type is available to aliens with special status and non-qualified aliens under the age of 65 who would receive Standard but for their immigration status except for women described in **Section 2.1.3.1.7**.

Persons receiving Limited coverage are eligible only for emergency services as described in **Section 2.1.3.7.1**.

2.1.3.7.1 Eligibility Requirements

MassHealth Limited is available to persons who meet the financial and categorical requirements for Standard coverage and who are aliens with special status as defined in

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Section 2.1.2.1.3 or nonqualified aliens as defined in Section 2.1.2.1.5. This does not include women described in **Section 2.1.3.1.7**

Limited provides for the care and services necessary for the treatment of an emergency medical condition. Such care and services do not include those related to organ-transplant procedures.

The alien must have a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- 1) Placing the patient's health in serious jeopardy;
- 2) Serious impairment of bodily functions; or
- 3) Serious dysfunction of any bodily organ or part.

The alien must meet all other requirements of MassHealth with the exception of furnishing or applying for a social security number.

Aliens lawfully admitted for a temporary purpose such as students, visitors, and diplomats are eligible for Limited provided they meet all other eligibility requirements including residence.

2.1.3.7.2 Medical Coverage Date

The begin date of medical coverage for MassHealth Limited shall be ten (10) calendar days prior to the date a MBR is received at any MEC or outreach site, provided all required verifications with the exception of documentation of immigration status have been submitted within sixty (60) calendar days of the date of the information request.

If required verifications are received after the sixty (60) calendar day period, the begin date of medical coverage shall be ten (10) calendar days prior to the date on which the verifications were received, provided such verifications are received within one (1) year of receipt of the MBR.

2.1.4 Calculation of Financial Eligibility

2.1.4.1 Groupings

In the determination of eligibility for MassHealth, the gross income of all family group members is counted and compared to an income standard based on the family group size. Family groups include families, couples, or individuals.

2.1.4.1.1 Family

Family includes a natural, step or adoptive parents(s) who reside with their child (ren) under age 19, and any of their children, or whose child (ren) are absent from home to attend school; or siblings under age 19, and any of their children, who reside together when no parent(s) are present. A family includes both parents when they are mutually

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responsible for one or more children who reside with them.

Family may also include a child or children under age 19, any of their children, and their caretaker relative when no parent is living in the home. A caretaker relative may choose whether or not to be part of the family.

2.1.4.1.2 Couple

Persons who are married to each other and live together and have no children under the age of 19 residing with them or children under the age of 19 who are absent for the purpose of attending school.

2.1.4.1.3 Individual

A person not included in the definition of family or couple.

2.1.4.2 Countability of Income

Eligibility is based on the family group's gross countable earned and unearned income and countable rental income, as defined in this section.

2.1.4.2.1 Gross Earned Income

This is the total amount of compensation received from work or services performed before any income deduction.

Earned income for the self-employed is the total amount of business income listed or allowable, less any allowable deductions, listed on a U.S. Tax Return.

For persons who are seasonally employed, annual gross income is divided by 12 to obtain a monthly gross income with the following exception. If the person experiences a disabling illness or accident during or after the seasonal employment period which prevents the person's continued or future employment, only current available income shall be considered in the eligibility determination.

2.1.4.2.2 Gross Unearned Income

This is income that does not directly result from the individual's own labor. The total amount of unearned income before any deductions is countable. Unearned income includes, but is not limited to, social security benefits, railroad retirement benefits, pensions, annuities, federal veterans' benefits, and interest and dividend income.

2.1.4.2.3 Rental Income

Rental income is the total amount of gross income, received from a tenant or boarder, less any allowable deductions listed on an applicant's or member's U.S. Tax Return.

2.1.4.3 Non-Countable Income

The following types of income are non-countable in the determination of eligibility:

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- Income received by a TAFDC, EAEDC, or SSI recipient;
- Sheltered workshop earnings;
 - The portion of Federal veterans benefits identified as aid and attendance benefits, unreimbursed medical expenses, housebound benefits, or enhanced benefits;
 - Income-in-kind;
 - Temporary income from U.S. Census Bureau related to Census 2000 activities, or federal unemployment benefits related to the termination of that temporary income.
 - Roomer and boarder income; and
 - Any other income excluded as provided by federal laws other than the Social Security Act (see 42 C.F.R. Part 416, Appendix to Subpart K).

2.1.4.4 Verification of Income

Verification of gross monthly income is mandatory. In lieu of any of the specific sources and verifications listed below, any other evidence of the applicant's or member's earned or unearned income is acceptable.

2.1.4.4.1 Earned income

The following are required to verify earned income:

- Two recent pay stubs;
- A signed statement from the employer; or
- Most recent U.S. Tax Return.

2.1.4.4.2 Unearned Income

The following are required to verify unearned income:

- Copy of a recent check or stub showing gross income from the source; or
- Statement from the income source, where matching is not available.

2.1.4.4.3 Rental Income

The following are required to verify rental income

- Most recent U.S. Tax return

2.1.4.5 Transfer of Income

All family group members are required to avail themselves of all potential income. If MassHealth determines that income has been transferred for the primary purpose of establishing eligibility for MassHealth, the income is counted as if it were received. If MassHealth is unable to determine the amount of available income, the family group will remain ineligible until such information is made available.

2.1.4.6 Calculation of Financial Eligibility

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The financial eligibility for various MassHealth coverage types is determined by comparing the family group's gross monthly income with the applicable income standard for the specific coverage. The monthly income standards are determined according to annual FPL standards published by the Federal Register using the following formula:

- Divide the annual federal poverty income standard as it appears in the Federal Register by 12;
- Multiply the un-rounded monthly income standard by the applicable FPL standard (e.g. 133%); and
- Round up to the next whole dollar to arrive at the monthly income standards.

MassHealth will adjust these standards in April of each calendar year.

2.1.4.7 COLA Protections

Members whose income increases each January as the result of a cost of living adjustment shall remain eligible until the subsequent FPL adjustment.

2.1.4.8 The One-Time Deductible (Spenddown)

Disabled adults described in **Section 2.1.3.3.2** may establish eligibility by meeting a deductible. Once the deductible has been met, the person may be assessed a monthly (health insurance) premium in accordance with the premium schedule in **Attachment 2.1**.

2.1.4.8.1 Definition of the Deductible

The deductible is the total dollar amount of incurred medical expenses that an applicant, whose gross family group income exceeds the applicable income standard, must be responsible for before CommonHealth eligibility is established. Any bills or portions of bills that are used to meet the deductible shall not be paid by any MassHealth coverage type and remain the responsibility of the applicant.

2.1.4.8.2 The Deductible Period

The deductible period is a six (6) month period beginning ten (10) days prior to the date a Medical Benefit Request is received in any MEC or outreach site.

2.1.4.8.3 Calculating the Deductible

The amount of the deductible is determined by comparing the gross income of the family group to the MassHealth Deductible Income Standard and Multiplying the excess by (6).

The current MassHealth Deductible Standards are:

Family Group Size Income Standards

1. \$542

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2. \$670
3. \$795
4. \$911
5. \$1036
6. \$1161
7. \$1286
8. \$1403
9. \$1528
10. \$1653

\$133 for each additional person

2.1.4.8.4 Notification of the Deductible

The disabled applicant who has excess monthly income shall be informed that he or she is currently ineligible for MassHealth but may establish eligibility by meeting the deductible. The applicant shall be informed in writing of the following:

- 1) The deductible amount; and
- 2) The start and end dates of the deductible period.

A person who meets a deductible shall be eligible for CommonHealth effective with the begin date of the deductible period.

2.1.4.8.5 Persons Deemed to Have Met a Deductible

The following disabled adults shall be considered to have met a deductible:

- Disabled adults who were receiving MassHealth on July 1, 1997 as the result of meeting a deductible; and
- Disabled adults who were denied with a deductible prior to July 1, 1997 but, who submit medical bills after July 1, 1997 to meet the deductible.

2.1.4.8.6 Submission of Bills to Meet the Deductible

To establish eligibility, the applicant or member must submit verification of medical bills whose total equals or exceeds the deductible and that meet the following criteria:

- 1) The bill must not be subject to further payment by health insurance or other liable third-party coverage including the state-legislated Uncompensated Care Pool;
- 2) The bill must be for an allowable medical or remedial expense as provided below; and
- 3) The bill must be unpaid and a current liability, or if paid, paid during the current deductible period.

2.1.4.8.7 Expenses Used to Meet the Deductible

Bills to meet the deductible shall be applied in the following order:

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- 1) Medicare and other health insurance premiums credited prospectively for the cost of six months' coverage;
- 2) Expenses incurred by any member of the family group for necessary medical and remedial services that are recognized under state law but not covered by MassHealth;
- 3) Expenses incurred by any member of the family group for necessary medical and remedial services that are covered by the MassHealth Program.

2.1.4.8.8 Expenses that Cannot Be Used to Meet the Deductible

Medical expenses that may not be applied to meet the deductible include, but are not limited to, the following:

- 1) Cosmetic surgery;
- 2) Rest-home care;
- 3) Weight-training equipment;
- 4) Massage therapy;
- 5) Special diets; and
- 6) Room and board charges for individuals in residential programs.

2.1.4.9 Verification of Medical Expenses

Medical expenses must be verified by a bill or written statement from a health-care provider with the exception of expenses for nonprescription drugs, which must be verified by a receipt from the provider of the drug.

Verifications must include all of the following information:

- 1) The type of service provided;
- 2) The name of the person for whom the service was provided;
- 3) The amount charged for the service including the current balance; and
- 4) the date of service.

2.1.4.10 Premiums

Certain Standard, CommonHealth, and Family Assistance members may be assessed a monthly (health insurance) premium.

Except for women described at Section 2.1.3.1.7, premiums for Standard eligible members are based on gross countable income and family group size as it compares to the federal poverty level, and whether or not the member has other health insurance. Standard disabled adult members who are not parents and whose family's gross monthly income is above 114 percent of the federal poverty level will be charged a premium of \$12 per family group. Standard eligible members who are parents or children and whose family's gross monthly income is above 133 percent of the federal poverty level will be charged a premium of \$12 per child, up to a maximum of \$15 per family group.

Premiums for women described at Section 2.1.3.1.7 whose family's gross monthly income is above 133% of the federal poverty level are based on gross countable income

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and family group size as it compares to the federal poverty level. Monthly premiums are assessed in accordance with the following premium schedule.

% of Federal Poverty Level (FPL)	Premium Cost
Above 133 to 160	\$15
Above 160 to 170	\$20
Above 170 to 180	\$25
Above 180 to 190	\$30
Above 190 to 200	\$35
Above 200 to 210	\$40
Above 210 to 220	\$48
Above 220 to 230	\$56
Above 230 to 240	\$64
Above 240 to 250	\$72

Standard eligible infants, children under age six (6), pregnant women, and individuals who meet the requirements set forth in **Section 2.1.3.1.1.2** will not be charged a premium.

CommonHealth premiums are based on gross countable income and family group size as it compares to the federal poverty level, and whether or not the member has other health insurance. Where more than one family group member receives CommonHealth, only one (1) premium per family group shall be assessed. CommonHealth eligible members assessed a monthly premium in accordance with the premium schedule below:

Full payment is required of members who have no health insurance and of members for whom MassHealth is paying a portion of their health-insurance premium. The full premium formula is provided below.

FULL PREMIUM FORMULA		
Base Premium	Additional Premium Cost	Range of Premium Cost
Above 100% to 150%	\$15 per family group	\$15
Above 150% FPL— start at \$15	Add \$5 for each additional 10% FPL until 200% FPL	\$15 — \$35
Above 200% FPL— start at \$40	Add \$8 for each additional 10% FPL until 400% FPL	\$40 — \$192
Above 400% FPL— start at \$202	Add \$10 for each additional 10% FPL until 600% FPL	\$202 — \$392
Above 600% FPL— start at \$404	Add \$12 for each additional 10% FPL until 800% FPL	\$404 — \$632
Above 800% FPL— start at \$646	Add \$14 for each additional 10% FPL until 1000%	\$646 — \$912
Above 1000% FPL— start at \$928	Add \$16 for each additional 10% FPL	\$928 + greater

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CommonHealth children below 300% FPL use the below schedule (above 300% FPL, use the above schedule)

% of Federal Poverty Level (FPL)	Premium Cost
Above 100% to 150%	\$12 per child (\$15 per family group maximum)
Above 150% to 200%	\$12 per child (\$36 per family group maximum)
Above 200% to 250%	\$20 per child (\$60 per family group maximum)
Above 250% to 300%	\$28 per child (\$84 per family group maximum)

Monthly Supplemental Premium Formula. A lower supplemental payment is required of members who have health insurance to which MassHealth does not contribute. The supplemental premium formula is provided below.

SUPPLEMENTAL PREMIUM FORMULA	
% of Federal Poverty Level (FPL)	Premium Cost
Above 100% to 150%	60% of full premium
Above 150% to 200%	60% of full premium
Above 200% to 400%	65% of full premium
Above 400% to 600%	70% of full premium
Above 600% to 800%	75% of full premium
Above 800% to 1000%	80% of full premium
Above 1000%	85% of full premium

Family Assistance premiums are based on the family group's gross countable income and family group size as it compares to the federal poverty level. Family Assistance eligible members (with the exception of persons with HIV disease, whose premiums are calculated as if the member is receiving CommonHealth benefits) whose family's gross monthly income is between 100 and 150 percent of the federal poverty level will be charged a premium of \$12 per child, up to a maximum of \$15 per family group, and \$27 per childless adult, up to a maximum of \$54 per family group. Family Assistance eligible members whose family's gross monthly income is between 150 and 200 percent of the federal poverty level will be charged a premium of \$12 per child, up to a maximum of \$36 per family group, and \$27 per childless adult, up to a maximum of \$54 per family group.

In the event a household contains at least two members who are receiving different benefit types and who would otherwise be assessed two different premiums the household shall be assessed only the highest of all applicable premiums.

2.1.4.10.1 Premium Payments:

Persons described in **Sections 2.1.3.1.1, 2.1.3.1.2.1, 2.1.3.1.4, 2.1.3.1.6, 2.1.3.3.1, 2.1.3.3.3, 2.1.3.3.4, 2.1.3.4.1.1, and 2.1.3.4.1.3** who are assessed a premium, shall be

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responsible for monthly premium payments to MassHealth beginning with the calendar month following the date of their eligibility determination.

Persons described in **Section 2.1.3.3.2**, who are assessed a premium, shall be responsible for monthly premium payments, beginning with the calendar month following the end date of the deductible period or the month after the deductible has been met, whichever is later.

Members who are determined eligible for a new category for which no premium payment is required shall cease to be responsible for the premium payment to MassHealth as of the calendar month in which the coverage changes.

Members who are assessed a revised premium payment as the result of a reported change shall be responsible for the new monthly premium payment beginning with the calendar month following the reported change.

2.1.4.10.2 Delinquent Premium Payments

If MassHealth has billed a member for a premium payment, and the member does not pay all of the amount billed within 60 days of the date on the bill, then the member's eligibility for benefits will be terminated, except as provided in section 2.1.4.11. The member will receive a notice of termination prior to the date of termination.

Provided no waiting list has been established pursuant to Section 2.0 of this Chapter, after the member has paid in full all payments due, and has established a payment plan with MassHealth, MassHealth will reactivate coverage. If a waiting list has been established, adults (age 19 and over) who have been terminated due to nonpayment of premiums will be placed on the waiting list upon payment of all payments due. They will not be allowed to reenroll until MassHealth is able to reopen enrollment for those placed on the waiting list. When is able to open enrollment for those on the waiting list, their eligibility will be processed in the order they were placed on the waiting list.

2.1.4.10.2.1 Repayment Process

The member's eligibility will not be terminated if the member, prior to the date of termination:

Pays all amounts which have been billed 60 days or more prior to the date such payment is made; or establishes a payment plan acceptable to MassHealth. After such a payment plan has been established, MassHealth will bill the member for (a) payments in accordance with the payment plan, and (b) monthly premiums due subsequent to the establishment of the payment plan. If the member does not make payments in accordance with the payment plan within 30 days of the date on the bill, the member's eligibility will be terminated. If the member does not pay monthly

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premiums due subsequent to the establishment of the payment plan within 60 days of the date on the bill, the member's eligibility will be terminated.

2.1.4.11 Waiver of Premiums

If MassHealth determines that the requirement to pay a premium results in an extreme financial hardship for a MassHealth member, MassHealth may, in its sole discretion, waive payment of the premium or reduce the amount of the premiums assessed to a family or individual.

2.1.4.12 Voluntary Withdrawal

In case of a member's voluntary withdrawal, coverage shall continue, and the member shall be responsible for payment of premiums through the end of the calendar month of withdrawal.

2.1.4.13 Change in Premium Calculation

The premium amount is re-calculated when MassHealth is informed of changes in income, family group size, or health insurance status, and whenever an adjustment is made in the Standard, CommonHealth, or Family Assistance premium amounts and/or schedules.

2.2.1 Data Matching and Verification

2.2.1.1 Process for Data Matching

MassHealth initiates matches with other agencies, health insurance carriers, and employers to obtain information necessary to confirm or determine initial and continued eligibility. These agencies and matches include but are not limited to the following: The Department of Employment and Training (DET), Bureau of Vital Statistics,

Veteran's Services, Department of Revenue (DOR), Bureau of Special Investigations (BSI), Internal Revenue Service (IRS), Social Security Administration (SSA), Alien Verification Information System, Department of Youth Services (DYS), Department of Social Services (DSS), Department of Correction (DOC) and the Department of Transitional Assistance (DTA).

2.2.1.2 Verification Requirements

Verification only of the following (through either the customer or automated matching) is a prerequisite for eligibility determination:

- Income (for all except MassHealth Prenatal, and for presumptive eligibility determinations for MassHealth Standard and MassHealth Family Assistance, and for those without income);
- Disability (for CommonHealth, Standard or Limited);

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- TPL (from accident or injury);
- SSN;
- Citizenship and immigration status in accordance with Section 2.1.2.2;
- HIV disease in accordance with Section 2.1.3.4.5.1;
- Absent parent information;
- Unemployment (for Basic and Essential); and
- Access to, and availability of, health insurance.

2.2.2 Medical Security Plan Eligibility

The Massachusetts Division of Unemployment Assistance (DUA) is responsible for administering the Medical Security Plan (MSP). The MSP offers health insurance to individuals receiving DUA unemployment benefits by paying all or part of the premiums of existing health insurance, such as employer-sponsored insurance continued through COBRA, or all or part of the premiums of indemnity coverage.

Unemployment insurance recipients whose income does not exceed 400% FPL are eligible for the Medical Security Plan. There is no waiting period for eligibility to this program. A few exceptions to this waiting period are those individuals for whom COBRA insurance is available, individuals whose last employer was the military or federal government, those who worked in Massachusetts but are non-resident now, and those who are resident but whose employment was out of state. The data available from DUA identifies these situations.

2.2.3 Notice

All applicants and members shall receive a written notice of the determination of eligibility for MassHealth. The notice will contain the applicable eligibility decision for each member of the household who has requested MassHealth.

Where the notice is an approval, it will provide the coverage type for which the member is eligible, the medical coverage date and, where applicable, the amount of the premium or subsidy payment. Denials will provide the reason, the regulatory cite, and if applicable, the deductible amount and deductible period. Members will also receive a notice of loss of coverage or any changes in a coverage type, premium payment, or subsidy.

Applicants will be notified if they have been placed on a waiting list for the MassHealth Family Assistance program due to a state law limiting the number of adults who can enroll in that programs and will receive a notice of eligibility when MassHealth determines they can be reenrolled.

All notices with the exception of those regarding eligibility for Prenatal and presumptive eligibility of children for Standard and Family Assistance provide

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information regarding an applicant's or member's right to a fair hearing. Family Assistance members who receive a premium assistance payment will have the opportunity to appeal the MassHealth decision, including the calculation of the premium assistance payment. Information regarding the appeal process is found in MassHealth regulations at 130 CMR 610.000.

2.2.4 Referred Eligibles

Several groups receiving benefits from DTA receive MassHealth as a result of their eligibility for cash assistance. These groups include members in the following categories:

Elderly/SSI
Disabled/SSI
EAEDC (state-funded until enrolled under Basic)

SSI members all receive Standard. EAEDC members, though normally eligible for enrollment in Basic, are potentially eligible for several coverage types and MassHealth rules must be applied by the system to determine the most comprehensive coverage to which they are entitled.

TAFDC recipients who meet the requirements of section 1931 of Title XIX (42 U.S.C. section 1396U-1) are automatically eligible for Standard.

Assignment of the appropriate coverage type for these cases is accomplished through automated data exchange.

2.2.4.1.1 Transition Groups

Transition groups are those, whose eligibility must be re-determined under a different system or a different set of eligibility rules.

When a TAFDC or SSI member loses cash assistance, MassHealth benefits are extended for a prescribed period of time (*e.g.* Transition Medical Assistance); simultaneously closed (*e.g.*, death); or the member is sent a re-determination if the household is still potentially eligible for MassHealth (*e.g.* failed to comply with a work requirement). These cases have eligibility tested using MassHealth rules.

MassHealth transition groups consist of cases, or households, that move into or out of Traditional Medicaid based on changes such as 65th birthday or admission to (or discharge from) a long term care (LTC) facility. These cases must have eligibility redetermined under the applicable eligibility rules.

2.3 POST-AUDIT REVIEW

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Under the demonstration, MassHealth will use an alternative quality control review that is designed to meet its changing needs as well as assist in maintaining program integrity by ensuring that services are rendered only to those meeting the eligibility standards.

This review process will assist MassHealth planners in developing, maintaining and validating policy which will be of value in securing the level of confidence in the MassHealth programs that is required by the general public, Legislators and the Executive Office. This process will also provide CMS with information on the findings and identify areas of improvement.

Based on MassHealth's approved alternative QC process, it is understood that MassHealth will be assigned an MEQC payment error rate equal to the FFY'96 state error rate. This error rate will be assigned for the duration of the 1115 waiver demonstration project.

2.3.1 Description of the Alternative Quality Control (QC) Process

Over the demonstration period MassHealth proposes to complete a series of evaluation or information studies related to MassHealth's eligibility policies, procedures, and processes.

Target populations from both the demonstration and non-demonstration coverage groups will be selected for focused reviews and studies, as required by Special Term and Condition No. 21, general topics shall include the traditional (over-65) Medicaid population and a process to verify eligibility for the Insurance Partnership. The proposals will be submitted to CMS each year for prior approval in accordance with timetables set by CMS.

Reports on findings for any new studies completed during the life of the waiver will be submitted no later than six months after the completion of the review. A sample time line for new studies and reviews is listed below:

Submit idea to CMS	Sample Period	Review & Analysis	Submit Report to CMS
1 month prior	3 month period	6 month period	Following month

2.3.2. Validation of the Division's Classification of Expansion and Non-expansion Eligibles

MEQC will conduct a validation review to determine if the MA21 eligibility system is placing members in the correct category of assistance. MassHealth then uses this categorization to assess if the member is in the base, 1902 (R)(2), or expansion population, MEQC will perform this review for the correct categorization by the system of the expansion and non-expansion cases by drawing 25 cases at random each quarter

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from the MA21 universe; and reviewing the “case record” (including the paper case record and the computer system) to determine that the correct information is on the system and the information correctly classifies the case.

2.3.3 IP Subsidy Validation Study

MEQC will conduct an annual validation of the premium assistance payment amounts made for the subsidy of employer-sponsored health insurance.

2.3.4 Traditional Medicaid /Health Care Reform Study

Every six months, MEQC will alternate between studies on various aspects of eligibility for (1) the MassHealth “traditional” Medicaid population – including those over 65 and members needing long-term-care services and (2) the MassHealth Health Care Reform population - including members under 65 and non-institutionalized.

2.3.5 Corrective Action

Statistical data generated during the review process will be utilized to analyze trends, identify error prone cases and assess staffing, training, policy or legislative needs. MassHealth will formulate the corrective action process.

Corrective action plans and findings will be transmitted to CMS.

3.0 Description of MassHealth Covered Services and Delivery Systems

This section describes, for each MassHealth coverage type, its covered services and available delivery options, including managed care networks. It also describes the Medical Security Plan, which is administered by the Division of Unemployment Assistance.

3.1 Covered Services and Delivery Systems Options by Coverage Type

3.2 Primary Care Clinician (PCC) Plan

3.3 Behavioral Health Plan (BHP)

3.4 Managed Care Organization (MCO) Plan

3.5 Fee-for-Service

3.6 Premium Assistance

3.1 Covered Services and Delivery Systems Options By Coverage Type

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3.1.1 MassHealth Standard

3.1.1.1 Standard Eligible Populations: Children, parents, pregnant women, disabled individual and certain women with breast or cervical cancer. Eligibility for MassHealth Standard is described in section 2.1.3.1.

3.1.1.2 Standard Covered Services (subject to applicable limits):

Standard members receive State Plan services. Individuals under age 21 who are eligible for Standard under the Demonstration will receive EPSDT coverage.

Standard and CommonHealth are the only coverage types under the Demonstration that receive EPSDT.

3.1.1.3 Standard Cost Sharing Requirements

Standard eligible infants, children under age 6, pregnant women, and individuals who meet the requirements set forth in **Section 2.1.3.1.1.2** will not be charged premiums. There are also no premiums for Standard eligible members whose family group's gross monthly income is at or below 114% FPL. Disabled Standard eligible members whose family's gross monthly income is at or above 114% FPL; Standard eligible parents and children whose family's gross monthly income is at or above 133% FPL; and women who are eligible for Standard based on a diagnosis of breast or cervical cancer and whose family's gross monthly income is at or above 133% FPL may be assessed premiums. Applicable premiums are described in **Section 2.1.4.10**.

Co-pay requirements for adults are \$1.00 for generic drugs and \$3.00 for brand name drugs for services provided in a pharmacy and \$3.00 for non-emergency ER use and certain acute inpatient hospital stays. Members do not have a separate co-payment for pharmaceuticals administered as part of a hospital stay. Emergency services, family planning services and behavioral health hospital services are exempt from this cost-sharing.

Members who are under 19, pregnant or in a post-partum period, receiving hospice care or have comprehensive medical third party insurance do not have to pay cost-sharing. A member does not have to pay a co-payment on pharmacy services if that member has reached the calendar year cap on pharmacy services in the calendar year in which the pharmacy service is provided. The pharmacy services cap is \$200 per calendar year. A member does not have to pay a co-payment on non-pharmacy services if that member has reached the calendar year cap on non-pharmacy services in the calendar year in which the non-pharmacy service is provided. The non-pharmacy services cap is \$36 per calendar year.

3.1.1.4 Standard Delivery system options

Except as described in 3.1.1.5, Standard members, who do not have third party insurance, must choose either: a managed care organization (MCO), described in 3.4; or, the primary care clinician (PCC) plan, described in 3.2. Members who

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choose the PCC plan will have behavioral health services provided by the MassHealth behavioral health program (BHP) contractor, as described in 3.3. Standard members who have other insurance may obtain covered services that are not provided by the third-party insurer from any MassHealth provider on a fee-for-service basis, described in 3.5. Members who are receiving presumptive or other time-limited benefits will obtain covered services on a fee-for-service basis. Members who have employer-sponsored health insurance may be eligible for premium assistance, as described in 3.6.

3.1.1.5 Special Delivery Arrangements for Certain Standard Populations

3.1.1.5.1 Women with Breast or Cervical Cancer

Women with Breast or Cervical Cancer, who are eligible for Standard as described in 2.1.3.1.6, must enroll in the MassHealth PCC plan. Behavioral health services are provided by the MassHealth behavioral health contractor.

Standard-eligible children who are in the care or custody of the Department of Social Services (DSS) or the Division of Youth Services (DYS)

Children who are eligible for MassHealth Standard who are in care or custody of DSS or DYS may receive either managed care services, or services on a fee-for-service basis (except for behavioral health services). Behavioral health services for all children in the care or custody of DSS or DYS who are not enrolled in an MCO are provided by the MassHealth behavioral health contractor.

3.1.1.5.2 MHSPY—Mental Health Services Program for Youth

Introduction

The Mental Health Services Program for Youth (MHSPY) Pilot tests the effectiveness of a specialized system of care managed by an MCO for young people with serious emotional disturbance. Enrollment is voluntary for eligible MassHealth members. Specific innovations being tested include: integrating multiple funding streams for children with multiple need, allowing one responsible entity, the MCO, to plan, provide or arrange for all service; and developing individualized service plans in collaboration with the child's family.

The Massachusetts MHSPY pilot is a collaborative effort of MassHealth, the state Departments of Education (DOE), Mental Health (DMH), Social Services (DSS) and Youth Services (DYS) and the school departments in the MHSPY Service Area. MHSPY blends funding from the following payer agencies: MassHealth, DOE, DMH and DSS. EOHHS is the lead agency for the MHSPY Pilot and manages the contract with the Contractor. There are Interdepartmental Service Agreements (ISAs) between each of the payer agencies and EOHHS. There is multi-party MHSPY Steering Committee

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consisting of representatives of each of the collaborating schools and agencies and the contractor, and parents of children with serious emotional disturbance. There are also two sub-committees of the MHSPY Steering committee, called Area Level Operations Teams (ALOT Teams), which provide oversight of referrals and enrollments, operations, and service utilization for the Steering committee.

The contractor for the MHSPY Pilot operates the system of care and provides, directly or through contracted providers, all medically necessary medical, mental health, substance abuse and social support service to MHSPY Enrollees.

The capacity of the MHSPY Pilot is limited pursuant to the provisions of the CMS-approved contract between EOHHS and the Contractor.

In general, those portions MCO Plan as described in section 3.4 are also applicable to the MHSPY Pilot and are not addressed in this section. Only those aspects of the MHSPY Pilot that differ from the MCO Plan are addressed here.

Eligibility

To be eligible, a prospective MHSPY Pilot Enrollee must meet all of the following criteria:

- **MassHealth Eligibility:** MassHealth Member enrolled in the MassHealth Standard Benefit Plan.
- **Geographic Area:** Resident of, or expected to transition back within six months of enrollment in the MHSPY Pilot to the MHSPY Service Area. ;
- **Age:** Age 3 through 18;
- **Multi-Agency Need:** Eligible for MassHealth managed care and for services from at least one of the following: the Department of Mental Health; the Department of Social Services; the Department of Youth Services; or the Special Education Departments of the MHSPY Service Area.
- **Functional Level:** A score of 40 or higher on the Child and Adolescent Functional Assessment Scale (CAFAS), scored within the previous three months.
- **Cognitive Level:** An IQ score of 70 or above.
- **Duration:** symptoms or functional impairment of at least six months duration and expected to persist for at least a year.
- **Risk of Out-of-Home Placement:** At risk of out-of-home placement or in an out-of-home placement and ready for a step-down placement or return home or other community residence.
- **Adult Participation on the Care Planning Team (CPT):** Must have at least one adult, at least 18 years of age, who agrees to participate on a MHSPY CPT. This person may be the Enrollee's parent or guardian, a state-

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appointed guardian, or any other adult approved by the Enrollee's parent or guardian.

- **Parental Consent:** The parent, guardian, prospective MHSPY Pilot Enrollee (if 18), or DSS in the case of children placed in its legal custody pursuant to court order, must consent to the prospective MHSPY Pilot Enrollee's participation in the MHSPY Pilot, including evaluation activities, and sign a release of information for all records. DSS may authorize the release of records of children in its custody for the purposes of participation in the MHSPY Pilot pursuant to its authority under M.G.L. c. 119, s.23.
- MassHealth will disenroll a MHSPY Enrollee from the MHSPY Pilot and he or she shall no longer be eligible for MHSPY Covered Services under any one or more of the following circumstances: loss of eligibility for the MassHealth Standard; ineligibility for service from all of the following; the Department of Mental Health, the Department of Social Services, the Department of Youth Services, or the Special Education Departments of the MHSPY Service Area; upon the MHSPY Enrollee's 19th birthday; establishment of permanent residence in a city or town outside of the MHSPY Service Area ; transfer to a Residential Program in which the length of stay is expected to be longer than six months; MassHealth's approval of a request by the Contractor for involuntary termination pursuant to Section 6.3.B.1.b of the Contract; a recommendation of the MHSPY Enrollee's CPT that the MHSPY Enrollee graduate from the MHSPY Pilot; receipt by MassHealth of the MHSPY Enrollee's voluntary disenrollment forms; and the end of the MHSPY Pilot, if applicable. MHSPY Enrollees who voluntarily disenroll or graduate from the MHSPY Pilot may not reenroll during the term of the MHSPY Pilot.

MHSPY Covered Services

The MHSPY Covered Services include all of the services covered under MassHealth's MCO contracts for MassHealth Standard eligible children and additional mental health and rehabilitative services designed to support the functioning of the child. (See Attachment 3.8A.)

Team Service Planning

A unique Care Planning Team plans services for each MHSPY enrollee, facilitated by one of the Contractor's MHSPY Care Managers. The CPT includes; the MHSPY Enrollee's parent or surrogate parent; the MHSPY enrollee, if appropriate; other people invited by the MHSPY enrollee or his or her parents, the MHSPY Care Manager and representatives of any State or Local government agencies or schools providing services to the MHSPY enrollee. It is a goal that the parents and the other non-professionals they invite constitute 50% of the membership of the CPT.

Member Enrollment

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Referrals to the MHSPY program are made by designated staff from each of the MHSPY referring agencies: the State Departments of Mental Health, Social Services and Youth Services and the Special Education Departments of the MHSPY Service Area.

Referrals are made to the MHSPY Enrollment Coordinator, who is a licensed or license-eligible mental health clinician hired and supervised by the Contractor. The MHSPY Enrollment Coordinator determines the prospective enrollee's clinical eligibility for MHSPY, obtains necessary consents from the parent or guardian, reviews pending enrollments with the ALOT Teams and facilitates the child's enrollment in MHSPY. If an opening in the program is not available, the child is placed on a waiting list and enrolled when space becomes available.

Disenrollment

The enrollee's CPT will regularly review progress toward goals identified in the Individual Care Plan (ICP). Part of each child's ICP will be a transition/discharge plan, the goal of which is to smoothly transition the child and family to less intensive outpatient care and other community resources.

Marketing and Outreach

The eligible population for the MHSPY Pilot is a limited group of high-risk children and adolescents. Outreach to potential MHSPY Enrollees and their families is conducted by referring agency direct service staff.

Program Requirements

In addition to the MCO Program requirements contained in the overall MCO contract, MassHealth has established program requirements specifically for the MHSPY Pilot (Section 6 of the Division's Contract with the Contractor). These address: the MHSPY Philosophy; Care Planning and Integration; Access; Member Services and Utilization; and Quality.

Improvement Goals

EOHHS will align MHSPY quality management with the MCO quality strategy plan referred to in section 6.0.

Evaluation

During State Fiscal Years 2005 and 2006, MassHealth is undertaking a program evaluation of all MHSPY data collected over the course of the pilot. Domains of the evaluation include: cost; service utilization; clinical measures of functioning; community tenure; school attendance; and family, youth and referring agency satisfaction.

Expenditure and Eligibles Reporting

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MassHealth maintains records of MHSPY enrollments and disenrollments. MassHealth reconciles estimated MHSPY capitation payments made to the contractor with actual MHSPY capitation payments, based on enrollment days, on a semi-annual basis.

Upon receipt of cost data from the Contractor, six months after the end of the fiscal year, MassHealth reconciles the actual MHSPY capitation payments with the Contractor's expenditures for MHSPY covered services and approved MHSPY Administrative Expenditures.

Prevention of Duplicate Claims for Federal Financial Participation

Each State fiscal year during the MHSPY pilot, MassHealth runs a report on all "pass through" claims (from other state agencies) associated with MHSPY enrollees during the year to screen for any duplication of services to these individuals. This process ensures that no duplicate claims for Federal Financial participation are made for MHSPY Enrollees.

Budget Neutrality Calculation

For the purposes of the Budget Neutrality calculation, only the MassHealth portion of the MHSPY Enrollees' costs shall be counted.

3.1.1.5.4 CFFC – Coordinated Family Focused Care

Introduction

Coordinated Family Focused Care, managed by the MassHealth Behavioral Health contractor, is a collaborative effort of MassHealth and the state Departments of Education (DOE), Mental Health (DMH), Social Services (DSS), and the Division of Youth Services (DYS) to build on the Mental Health Services Program for Youth and the Worcester Communities for Care experiences to develop a coordinated system of care for delivering services to certain MassHealth managed care-eligible children and adolescents with serious emotional disturbances.

CFFC is based on the *Child and Adolescent Service System Program* principles and the wraparound model of service planning. CFFC blends funding from the following payer agencies: MassHealth, DOE, DMH and DSS. There are Interdepartmental Service Agreements (ISAs) between each of the payer agencies and EOHHS. EOHHS is the lead agency and manages the contract with the MassHealth behavioral health plan (BHP) contractor to administer CFFC.

The BHP contractor is responsible for implementing and managing CFFC and will subcontract with a provider organization in each of the CFFC service area to implement CFFC. CFFC is collaboratively managed by the payer agencies through a multi-party CFFC Steering Committee, consisting

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of the representatives of the Executive Office of Health and Human Services, the payer agencies, the contractor, and at least one representative of parents of children with serious emotional disturbance.

The capacity of the CFFC initiative is limited pursuant to the provisions of the CMS-approved contract between EOHHS, on behalf of itself and the other payer agencies, and the contractor.

In general, all descriptions of the MassHealth Behavioral Health Program (BHP) in section 3.3, are also applicable to CFFC and are not addressed in this section. Only those aspects of CFFC that differ from the general BHP descriptions are addressed here.

Eligibility

To be eligible, a prospective CFFC enrollee must meet all of the following criteria:

1. MassHealth member enrolled in managed care;
2. Age 3 through 18 or up to age 22 if eligible for special education services;
3. Reside in a CFFC service area (the cities of Brockton, Lawrence, New Bedford, Springfield or Worcester);
4. Reside at home with family (biological, adoptive, foster, or caretaker relative) and be at risk of out-of-home placement because of SED; or be currently in an out-of-home placement and able to return to a home environment with appropriate services and supports
5. Meet criteria substantially similar to the definition of “Children with Serious Emotional Disturbance” in Section 191:2 (c) of the Public Health Service Act, as amended by Public Law 102-321: *Children who, currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) that results in functional impairment which substantially interferes with or limits the child’s role or functioning in family, school, or community activities. DSM-IV “V” codes, substance use, developmental disorders, and mental retardation are excluded, unless they co-occur with another diagnosable serious emotional disturbance. Children who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition.*
6. Have a score of 100 or higher, based on aggregation of all eight scales (with at least two subscale scores of at least 20), on the Child and Adolescent Functional Assessment Scale (CAFAS) or the Preschool and Early Childhood Functional Assess Scale (PECFAS) scored within the previous three months.
7. Caregiver consents to a referral to CFFC and agree to participate in CFFC.
8. Caregiver signs a consent form for the release of medical and other appropriate information.

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9. Referral assessment rules out less intensive levels of care as beneficial; and
10. Referral assessment determines that the child does not require more intensive levels of care due to dangerousness to self or others.

CFFC Services

The CFFC services include case management services using a care management model as well as child and family support services. These may include, without limitation: crisis services, family advocacy, short-term in-home and out-of-home respite, recreational and social habilitation services, mentors, peer support groups, non-medical transportation and limited flexible funds for small, specialized purchases. CFFC services include all of the services covered under MassHealth's BHP contract for Standard eligible children and additional mental health and rehabilitative services designed to support the functioning of the child.

Managed Care Networks

The CFFC program will be administered by MassHealth's behavioral health managed care contractor. The contractor will be responsible for implementing and managing CFFC and will sub-contract with a provider organization in each CFFC service area for direct service delivery. The contractor will monitor program quality and service utilization and will provide other administrative services such as claims processing and data collection and analysis.

Individual Care Planning

The subcontracted provider organization will be responsible for implementing the Individual Care Planning (ICP) process. Providers will employ Care Managers, who are licensed, or license-eligible mental health clinicians, and Family Partners, who are parents of children with serious emotional disturbance, who will work with children and their families to create individual Care Planning Teams (CPTs) for each child. The CPT includes the child's parent or surrogate parent, the child, if appropriate, other people invited by the family, the Care Manager, Family Partner, and representatives of any state agencies and/or schools providing services to the child. It is a goal that the parents and the other non-professionals they invite constitute 50% of the membership of the CPT. The CPT will identify the child and family's strengths, resources and needs and create an Individual Care Plan. Provider staff will also provide 24/7 crisis coverage to families of enrolled children as well as certain direct services as indicated in the care plan.

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Referrals

Referrals will be made directly to the local provider, and are accepted from any source for any child with MassHealth coverage who is eligible to be enrolled in the MassHealth PCC plan who lives within a region where CFFC is available.

Eligibility Determination & Enrollment

Clinical eligibility will be determined by the MassHealth behavioral health managed care contractor based on a review of an application for services and a clinical assessment performed by local provider staff.

Continuation of Program Enrollment/Discharge Planning

CPTs will regularly review the child's and family's progress toward goals identified in the Individual Care Plan. The behavioral health managed care contractor will also make quarterly evaluations of progress towards these goals. The contractor will seek consultation and input from the child's CPT before disenrolling and transitioning any member. Part of each child's Individual Care Plan will be a transition/discharge plan, the goal of which is to smoothly transition the child and family to less intensive outpatient care and other community resources.

Evaluation

The overall goal of the CFFC initiative is to support children and adolescents with serious emotional disturbance by building upon child and family strengths and available support systems in order to maintain and improve the child's ability to remain and function productively in the community. Specifically, the initiative hopes to achieve: improvements in child functioning, increased lengths of stay in the home or other community setting, reductions in the use of inpatient psychiatric services and long-term residential programs, increased school attendance and performance, reduced involvement with the juvenile justice system, and a high degree of parent and youth satisfaction with services.

Funds awarded to the Division by the Center for Health Care Strategies, Inc. will support the cost of the program evaluation. Outcomes to be measured include, without limitation, types and costs of services provided to the child and family during participation in CFFC, child functioning, community tenure, hospitalization rates, use of residential placements, school attendance and performance, juvenile justice involvement and family satisfaction.

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3.1.1.5.5 Special Kids/Special Care Pilot Program

Introduction

The Special Kids/Special Care Pilot program (Pilot) provides, through an MCO contractor, enhanced support and coordination of services for children who have been placed in the custody of DSS, who are living in a foster home at the time of enrollment and who have special health care needs. All applicable contract requirements related to Special Populations specified in current MCO contracts with MassHealth apply to this Pilot. The goal of this Pilot is to enhance the current managed care service delivery system to support foster children with special health care needs. In general, the description of MassHealth's MCO Program in section 3.4 is also applicable to this Pilot. Only those aspects of the Pilot that differ from the MCO description in 3.4 are addressed here.

The Pilot is a cooperative effort of MassHealth and DSS. EOHHS is the lead agency for the Pilot and manages its contract with the MCO for services delivered through the Pilot.

Eligibility

To participate in the Special Kids/Special Care Pilot, a child must be:

- 1) a MassHealth Standard member who is eligible to participate in managed care
- 2) a child in the custody of DSS living in a foster home at the time of enrollment who has the need for:
 - Complex medical management on a regular basis over a prolonged period of time; and
 - Direct administration of skilled-nursing care requiring complex nursing procedures on a regular basis over a prolonged period of time; or
 - Skilled assessment or monitoring on a regular basis over a prolonged period of time related to an unstable medical condition.

Referrals

DSS refers medical information about children it seeks to participate in the Pilot. EOHHS determines if the child's medical needs meet the criteria for participation in the Pilot. If the child is determined appropriate for the Special Kids/Special Care Pilot, the child will be enrolled into the MCO as a participant in the Pilot. Participation in the Pilot is voluntary.

Failure to meet the criteria for participation in the Pilot does not affect the child's ability to otherwise enroll in any MassHealth managed care plan or to remain in managed care eligible status. The Pilot will began operating in the

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Greater Boston/Boston Area, and has expanded operation to other major regional areas of the Commonwealth in which the contractor is approved to accept members.

Covered Services

Children in the Special Kids/ Special Care Pilot, like other children in DSS custody, receive all of the medical and behavioral health services covered under the MassHealth Standard coverage type.

The MCO contractor for the Special Kids/Special Care Pilot delivers medical and behavioral health services by using an enhanced care management model. This model includes care coordination and home visits by a care coordinator who is a mid-level practitioner. The care coordinator functions include but are not limited to:

- Working with the child/foster family and the DSS caseworker to assess child and foster family and development of a medical care plan;
- Authorizing and coordinating services included in the medical care plan;
- Monitoring the implementation of the medical care plan, and updating the plan as necessary; and,
- Acting as a liaison between the child/foster family and the health care provider.

The MCO care coordinator is responsible for coordinating medical services and the DSS worker is responsible for coordinating social services. They share information allowing each one to better plan and coordinate services.

Evaluation

An evaluation of the pilot has been conducted by the University of Massachusetts Center for Health Policy and Research. The evaluation included an analysis of claims and utilization data for a sample of enrollees, as well as in-person interviews with foster families, surveys of primary care providers and school nurses, and interviews with staff members involved with the pilot at MassHealth, DSS, and the MCO. In general, the evaluation found that the “Special Kids/Special Care” medical pilot has greatly enhanced access to and coordination of health services for a medically complex and heterogeneous group of children in foster care, and provides considerable support to foster parents in caring for these fragile children with round-the-clock needs.

3.1.2 MassHealth Basic

3.1.2.1 Basic Eligible Populations: persons receiving EAEDC cash benefits who are not eligible for Standard and certain Department of Mental Health (DMH) clients

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who are long-term unemployed. Eligibility for MassHealth Basic is described in section 2.1.3.5.

3.1.2.2 Basic Covered Services (subject to applicable limits): acute inpatient hospital; ambulatory surgery; audiologist; behavioral health (mental health and substance abuse); Chapter 766 (home assessments and participation in team meetings); chiropractor; community health center; dental; durable medical equipment and supplies; family planning; abortion; emergency ambulance; hearing aid; home health; laboratory; nurse midwife; nurse practitioner; orthotic; outpatient hospital; oxygen and respiratory therapy equipment; pharmacy; physician; podiatrist; prosthetic; rehabilitation (except in inpatient hospital settings); renal dialysis; speech and hearing; therapy (physical, occupational, speech/language); vision care; X-ray/radiology.

3.1.2.3 Basic Cost Sharing Requirements

MassHealth Basic eligibles do not pay a premium to MassHealth.
Co-payment requirements are the same as for Standard.

3.1.2.4 Basic Delivery System Options

Basic members, who do not have third party insurance, must be enrolled in either: a managed care organization (MCO), described in 3.4; or, the primary care clinician (PCC) plan, described in 3.2, in order to receive services. Members who enroll in the PCC plan will have behavioral health services provided by the MassHealth behavioral health program (BHP) contractor, as described in 3.3. Basic members who have other insurance may be eligible for premium assistance that will pay part or all of the member's private health insurance premium. Premium assistance payments will be made to the insurance company, employer, or the member or policyholder covered by the health insurance. Premium assistance covers the member's share of the health insurance premium. MassHealth will not pay for employer, union, or other group contributions to the health insurance premium payment. MassHealth will not pay any other cost-sharing obligations on behalf of the member, such as co-payments or deductibles. MassHealth will not pay for services that are not covered by the private health insurance.

3.1.3 MassHealth Essential

3.1.3.1 Essential Eligible Populations: long-term unemployed adults who are not eligible for Basic. Eligibility for MassHealth Essential is described in section 2.1.3.6.

3.1.3.2 Essential Covered Services (subject to applicable limits): acute inpatient hospital; ambulatory surgery; behavioral health (mental health and substance abuse); community health center; dental; durable medical equipment and supplies; family planning; abortion; emergency ambulance; laboratory; nurse

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practitioner; outpatient hospital; oxygen and respiratory therapy equipment; pharmacy; physician; podiatrist; prosthetic; rehabilitation (except in inpatient hospital settings); renal dialysis; speech and hearing; therapy (physical, occupational, speech/language); X-ray/radiology.

3.1.3.3 Essential Cost Sharing Requirements

MassHealth Essential eligibles do not pay a premium to MassHealth. Co-payment requirements are the same as for Standard.

3.1.3.4 Essential Delivery System Options

Essential members, who do not have third party insurance, must enroll in the primary care clinician (PCC) plan, described in 3.2, in order to receive services. Essential members who are enrolled in the PCC plan will have behavioral health services provided by the MassHealth behavioral health program (BHP) contractor, as described in 3.3. Essential members who have other insurance may be eligible for premium assistance that will pay part or all of the member's private health insurance premium. Premium assistance payments will be made to the insurance company, employer, or the member or policyholder covered by the health insurance. Premium assistance covers the member's share of the health insurance premium. MassHealth will not pay for employer, union, or other group contributions to the health insurance premium payment. MassHealth will not pay any other cost-sharing obligations on behalf of the member, such as co-payments or deductibles. MassHealth will not pay for services that are not covered by the private health insurance.

3.1.4 MassHealth CommonHealth

3.1.4.1 CommonHealth Eligible Populations: Disabled adults and children who are not eligible for Standard. Eligibility for MassHealth CommonHealth is described in section 2.1.3.3.

3.1.4.2 CommonHealth Covered Services (subject to applicable limitations): CommonHealth members receive State Plan services. Individuals under age 21 who are eligible for CommonHealth under the Demonstration will receive EPSDT coverage. Standard and CommonHealth are the only coverage types under the Demonstration that receive EPSDT.

3.1.4.3 CommonHealth Cost Sharing Requirements

No premium for CommonHealth members with incomes at or below 100% FPL; CommonHealth eligible members whose family's gross monthly income is above 100% FPL may be assessed premiums. Applicable premiums are described in **Section 2.1.4.10.**

Co-payment requirements are the same as for Standard.

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3.1.4.4 CommonHealth Delivery System Options

CommonHealth members generally receive services on a fee-for-service basis. CommonHealth members, who do not have third party insurance, may, at their option, choose either: a managed care organization (MCO), described in 3.4; or, the primary care clinician (PCC) plan, described in 3.2. Members who choose the PCC plan will have behavioral health services provided by the MassHealth behavioral health program (BHP) contractor, as described in 3.3. CommonHealth members who have other insurance may obtain covered services that are not provided by the third-party insurer from any MassHealth provider on a fee-for-service basis, described in 3.5. Members who are receiving time-limited benefits will obtain covered services on a fee-for-service basis. Members who have employer-sponsored health insurance may be eligible for premium assistance, as described in 3.6.

3.1.5 MassHealth Prenatal

3.1.5.1 Prenatal Eligible Population: pregnant women with self-declared income at or below

200% FPL. Eligibility for Prenatal is described in section 2.1.3.2.

3.1.5.2 Prenatal Covered Services: ambulatory prenatal care provided by a MassHealth provider.

3.1.5.3 Prenatal Cost Sharing Requirements: none

3.1.5.4 Prenatal Delivery Systems Options: Fee-for-service. Prenatal members (presumptively eligible pregnant members) are excluded from participation in managed care.

3.1.6 MassHealth Limited

3.1.6.1 Limited Eligible Population: non-qualified aliens, aliens with special status; and protected

aliens who would otherwise be eligible for MassHealth Standard but for their immigration status. Eligibility for MassHealth Limited is described in section 2.1.3.7.

3.1.6.2 Limited Covered Services: The MassHealth Limited coverage type covers only, on a fee- for-service basis, treatment of a medical condition (including labor and delivery) that manifests itself by acute symptoms of sufficient severity such that the absence of immediate medical attention reasonably could be expected to result in:

- Placing the member's health in serious jeopardy;

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- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

MassHealth will not cover payment of organ transplants under this coverage type. Any provider meeting the eligibility criteria set forth in MassHealth program regulations and provider agreements may provide services.

3.1.6.3 Limited Cost Sharing Requirements: none

3.1.6.4 Limited Delivery Systems Options: fee-for-service

3.1.7 MassHealth Family Assistance

3.1.7.1 Family Assistance Eligible Population: children who are not eligible for Standard or CommonHealth, adults who have employer-sponsored health insurance, and persons with HIV disease. Eligibility for Family Assistance is described in section 2.1.3.4.

3.1.7.2 Family Assistance Covered Services for those not receiving premium assistance (subject to applicable limits): acute inpatient hospital; ambulance (emergency only); ambulatory surgery; audiologist; behavioral health (mental health and substance abuse); Chapter 766 (home assessments and participation in team meetings); chiropractor; chronic disease and rehabilitation inpatient hospital; community health center; dental; durable medical equipment and supplies; early intervention; family planning; abortion; hearing aid; home health; hospice; laboratory; nurse midwife; nurse practitioner; orthotic; outpatient hospital; oxygen and respiratory therapy equipment; pharmacy; physician; podiatrist; prosthetic; rehabilitation; renal dialysis; speech and hearing; therapy (physical, occupational, speech/language); vision care; X-ray/radiology.

3.1.7.3 Family Assistance Cost Sharing Requirements

Family Assistance eligible members over 100%FPL must pay premiums as described in 2.1.4.10.

Co-pay requirements are the same as for Standard.

3.1.7.4 Family Assistance Delivery Systems Options

Children who do not have access to employer-sponsored health insurance must choose either: a managed care organization (MCO), described in 3.4; or, the primary care clinician (PCC) plan, described in 3.2. Members who choose the PCC plan will have behavioral health services provided by the MassHealth behavioral health program (BHP) contractor, as described in 3.3. Members who have access to employer-sponsored health insurance may be eligible for premium assistance, as described in 3.6. Fee-for-service coverage, described in section 3.5,

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is provided for Family Assistance children during the presumptive eligibility period and the time-limited periods associated with investigated and enrolling in available employer-sponsored health insurance.

Children in Family Assistance who have access to employer-sponsored health insurance that is cost-effective and meets the Basic Benefit Level (BBL) may only receive Premium Assistance, as described in section 3.6. MassHealth will not provide managed care or fee-for service coverage for Family Assistance children who are enrolled in employer-sponsored health insurance as described above.

Persons with HIV disease who are eligible for the purchase of medical benefits must enroll in the PCC/BH Plan as described in section 3.2 and 3.3. Persons with HIV disease who have access to employer-sponsored health insurance have the option of receiving premium assistance or purchase of medical benefits by MassHealth. If the member chooses to receive premium assistance, MassHealth will provide covered services that are not available from the private insurer on fee-for service basis.

Adults described in **Section 2.1.3.4.6.2** may only receive premium assistance. The premium assistance payment will be all or part of the individual's or family's portion of the private employer sponsored health insurance premium. The premium assistance payment equals the individual's portion of the premium less the applicable MassHealth premium as described in **Section 2.1.4.10**. MassHealth pays the premium assistance payment towards the health insurance premium to the member directly or, when possible, to the employer through a billing intermediary. Services not covered by the employer-sponsored health insurance are not provided by MassHealth.

3.1.8 Medical Security Plan

In addition to these MassHealth coverage types administered by EOHHS, the demonstration integrates the Medical Security Plan (MSP) into Massachusetts' effort to expand access to health insurance. The Medical Security Plan (MSP) is a health plan provided by the Division of Unemployment Assistance (DUA) to eligible Massachusetts residents who are receiving unemployment compensation benefits under the provisions of Chapter 151A of the Massachusetts General Laws.

A contractor administers MSP under contract with the DUA. As the administrator of the program, the contractor is responsible for: eligibility determinations; enrollment; claims processing and payment; and utilization management.

To be eligible for MSP coverage an individual must meet the following qualifications:

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- Be receiving (or eligible to receive) unemployment benefits from employment in Massachusetts;
- Be a Massachusetts resident; and
- Have a total family income for the six (6) months prior to the date of application plus projected income for the following six (6) months that is less than 400% of the Federal Poverty Level (FPL).

MSP provides health insurance to eligible individuals through two different programs:

- The Premium Assistance Plan: Partial premiums are paid to continue a health plan whose coverage began while the individual was still employed, and;
- The Direct Coverage Plan: If an eligible individual does not have the option of continuing an existing health plan or, if the individual qualifies for a hardship waiver, they are eligible to receive health care services through an indemnity plan.

3.2 Primary Care Clinician (PCC) Plan

3.2.1 PCC Provider Network

The PCC Plan is a primary care case management program administered by MassHealth. The PCC plan is available state-wide. In the PCC Plan, members enroll with a primary care clinician (PCC), who provides most primary and preventive care, and who is responsible for authorizing most specialty services. Members can access specialty services from any MassHealth provider, subject to PCC referral requirements. Descriptions in this section apply to all PCC-eligible coverage types.

3.2.2 PCC Qualifications and Responsibilities

Providers who wish to enroll as PCCs must be participating Medicaid providers, have current admitting privileges to at least one MassHealth-participating acute hospital, and practice in certain primary care specialty areas, or, in certain circumstances, another medical specialty. Interested providers must complete a PCC Provider Application, which is subject to approval by MassHealth. The following provider types may apply to be a PCC: individual physicians, independent nurse practitioners, community health centers, acute hospital outpatient departments and group practice organizations. In order to be enrolled as a PCC, an approved provider must sign MassHealth's PCC Contract and agree to fulfill the requirements specified in the Contract

The Contract requirements include, but are not limited to: informing members about service availability, referral processes, grievance procedures, after-hour call-in systems, and procedures for appointments, emergencies and urgent care; provide primary care as appropriate, providing 24-hour/7day/week coverage; maintaining an adequate appointment system that ensures prompt access to medical care, making necessary referrals, and monitoring all Medicaid-covered services which require a

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referral; and ensuring that care is provided in accordance with acceptable medical practices and professional standards.

3.2.3 Coordination of Services

Behavioral Health Program

Members enrolled in the PCC Plan receive mental health and substance abuse services through a single Behavioral Health Program contractor. Linkage between the PCC and the BHP are described in section 3.3.5.

School-Based Health Centers

The PCC Plan has activities in place to promote PCC linkages with School-Based Health Centers, which are available providers for PCC Plan members.

Municipal Medicaid

Municipal Medicaid providers have linkage PCPs in the PCC Plan. Special education-related services are paid for by either the municipality or the child's insurer, including MassHealth.

The Commonwealth assures that schools involved in the Medicaid program for the delivery of Medicaid covered services to Special Education students who are MassHealth eligible will be required to coordinate service delivery plans with the child's primary care provider. Further, the schools are empowered to act as an administrative arm of the Medicaid agency in order to ensure that the student receives Medicaid services that are appropriate and non-duplicative.

Family Planning

PCC Plan members are guaranteed confidentiality and unrestricted access to Family Planning services by being able to obtain these services from any participating provider without consulting their PCC or obtaining MassHealth's prior approval.

PCC Network Management

The PCC Plan purchases network management services from a contractor. Purchased services include, but are not limited to, a clinically focused management system that monitors, measures, and analyzes health care delivery by PCCs, conducts visits to certain PCC practices; produces data reports; assists PCCs in understanding their utilization statistics, conducts periodic regional information meetings with PCCs, and performs PCC provider-relations, assisting PCCs in delivering services to their members.

3.2.4 PCC Payment Mechanisms

Fee for Service

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MassHealth reimburses PCCs on a fee-for-service basis as described in **Section 3.5**.

Enhancement

MassHealth pays PCCs an enhancement for most office and home visits. An enhanced fee is not paid for referrals. MassHealth also pays PCCs an enhancement for providing screening services according to the periodicity schedule.

Prospective Interim Payment (PIP)

A prospective interim payment (PIP) is available to PCCs. The PIP is optional monthly cash advance for PCCs. The payment is made at the beginning of each month and is equal to twenty-five (25%) of the average monthly payment to the PCC for services to the PCC's Plan members in the previous quarter. Reconciliations occur using subsequent claims submissions.

Federal Qualified Health Center (FQHC) Payment Selective Contracting

FQHCs participate as providers in the PCC Plan. FQHCs participating as PCC providers are reimbursed on a fee-for service basis.

3.3 Behavioral Health Program (BHP)

Descriptions in this section apply to all BHP-eligible coverage types.

3.3.1 BHP Provider Network

The BHP offers a comprehensive provider network that includes a broad spectrum of mental health and substance abuse providers across the full-continuum of care. The provider network panel includes, but is not limited to:

- Individual practitioners (including psychiatrists, psychologists, and licensed social workers);
- Community mental health centers;
- Outpatient hospital clinics;
- Group practices;
- Inpatient facilities;
- Day programs;
- Evening programs;
- Partial hospitalization programs;
- Free-standing detoxification programs;
- Community support programs;
- Family stabilization programs;
- Narcotic treatment and counseling programs;
- Emergency service and crisis stabilization programs;
- Observation/holding beds;
- Day treatment programs for pregnant women;

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- Structured outpatient programs; and
- Home -based treatment programs.

3.3.2 BHP Provider Qualifications

Through its contract with its vendor, MassHealth requires that providers participating in the

BHP meets minimum credentialing requirements by type and service of provider. For new types of providers in the BHP network, the contractor is required to establish credentialing standards that are subject to review and approval by MassHealth.

The contract between MassHealth and the BHP contractor also contains requirements for mechanisms to detect and refer fraudulent providers to the appropriate authorities, including both EOHHS and the Medicaid Fraud control Unit of the Attorney General's Office. In addition, the contract requires that the vendor terminate any non-compliant provider from its network. Not all providers participating in the BHP are also Medicaid providers.

3.3.3 BHP Coordination of Care with Commonwealth Agencies

BHP members receive their acute mental health and substance abuse services through the BHP contractor and its subcontracted provider network. Non-acute mental health, substance abuse and other services, such as long-term hospitalization, residential services, vocational training, and other continuing care services are not covered by MassHealth. However, BHP Plan members who meet the eligibility requirements established by the following Commonwealth agencies can receive many of these non-acute care services from these agencies:

- Department of Education (DOE) and Local Education Authorities (LEA);
- Department of Mental Health (DMH);
- Department of Mental Retardation (DMR);
- Department of Public Health's Bureau of Substance Abuse Services (BSAS);
- Department of Social Services (DSS);
- Department of Youth Services (DYS); and
- Massachusetts Commission for the Deaf and Hard of Hearing.

3.3.5 BHP Linkage with the PCC Plan

The BHP contractor is required to facilitate communication and coordination of care with primary care clinicians and to establish annual BHP/PCC linkage improvement goals. These include:

- a policy that requires that the BHP contractor to communicate and coordinate the member's care with the member's PCC once written consent has been obtained to release information;

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- provide mental health and substance abuse educational and training for all PCCs;
- development and implementation of a care management program, which coordinates BH and medical care to the extent possible, and includes Intensive Clinical Management, care coordination, and targeted outreach components;
- identification of Covered Individuals who receive home health services who may benefit from, but are not receiving, BH services
- development and implementation of a Pharmacy Support System for Covered Individuals;
- conducting integrated PCC and BH Network provider quality forums; and
- developing and coordinating integrated PC and BH Clinical Advisory Committees

3.3.6 BHP Contractor's Administration of Diversionary Services

The BHP contractor is required to maintain a network of diversionary services that meet the access standards described, and to arrange, coordinate, and oversee the provision of medically necessary diversionary services. Diversionary services are provided as alternatives to inpatient mental health services in more community-based, less structured environments. The provision of these services are arranged for by the contractor's clinical staff who receive requests for hospitalization and then make a clinical decision to locate and authorize alternative or "diversionary" services for members, as appropriate.

3.3.6.1 Covered Diversionary Services

Diversionary services coordinated by the behavioral health contractor are described in the Covered Services section of the BHP contract. Diversionary services include state-plan and non-state plan services including, but not limited to:

- Community Support Program
- Community Crisis Stabilization
- Family Stabilization Team Services
- Partial Hospitalization
- Acute Treatment Services for Substance Abuse
- Clinical Support Services for Substance Abuse
- Transitional Care Unit Services
- Enhanced Acute Treatment Services
- Outpatient Day Services
- Psychiatric Day Treatment
- Intensive Outpatient Program
- Structured Outpatient Addiction Program
- Enhanced Residential Care
- Program of Assertive Community Treatment

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- Dialectical Behavioral Therapy
- Inpatient/Outpatient Bridge Visits
- Assessment for Safe and Appropriate Placement
- Comprehensive Child and Adolescent Assessment
- Emergency Services Program
- Community Based Acute Treatment for Children and Adolescents
- Intensive Community Based Acute Treatment for Children and Adolescents

3.3.6.2 Compliance in Administration of Diversionary Services

MassHealth monitors the BHP contractor's compliance for the administration of diversionary services through the following mechanisms:

- The BHP contractor is required to submit utilization and expenditure reports to MassHealth for all diversionary services provided during the reporting period. These reports must be submitted monthly, quarterly, semiannually, and annually. MassHealth analyzes and monitors these reports to determine if the utilization of diversionary services is clinically appropriate;
- MassHealth requires the BHP vendor to submit provider profiles on a semiannual basis;
- On a regular basis, MassHealth reviews patterns of care, monitors case manager activities, and randomly audits vendor records to monitor and ensure the appropriate use of diversionary services;
- On a regular basis, MassHealth requires the vendor to conduct provider site visits to review randomly selected medical records and participate in case conferences;
- MassHealth's BHP staff regularly join contractor staff supervision meetings and clinical management department meetings to monitor compliance with the administration of diversionary services; and
- EOHHS reviews and approves the contractor's medical necessity criteria, level of care determination criteria, and provider policies and procedures, along with the contractor's compliance with the administration of these items.

If EOHHS determined that the contractor was not in compliance with the administration of diversionary services, EOHHS would require the BHP contractor to implement a corrective action plan that had been reviewed and approved by EOHHS. EOHHS would then closely monitor the contractor's compliance with the approved corrective action plan.

3.3.8 Behavioral Health Program Payment Mechanisms

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Capitation and Risk Sharing Arrangements

Actuarially sound capitation rates will be established for the BHP vendor in accordance with 42 CFR 438 (the Balanced Budget Act regulations regarding Medicaid Managed Care). MassHealth's BHP contract specifies the requirements and rates relating to the different BHP-eligible MassHealth coverage types. Actuarially sound rates included the cost of all covered services, including diversionary services described in section 3.3.6.

MassHealth pays the contractor a monthly capitation rate on a per member per month basis for the three existing rating categories: (1) disabled, including SSI (2) families and children, including the AFDC population and (3) the Basic/Essential population.

3.4 Managed Care Organization (MCO) Program

3.4.1 MCO Provider Network

MassHealth contracts with MCOs, which provide comprehensive health coverage, including behavioral health services, to MassHealth Standard, Family Assistance and Basic members as well as to CommonHealth members who opt to participate in the MCO Network. MCO's may not be available in all areas of the state. In other areas of the state, one or more MCO's may be available. Descriptions in this section apply to all MCO-eligible coverage types.

3.4.2 Coordination of Services

SBHCs

Some MCOs have contractual agreements with SBHCs to pay the SBHC for care delivered to members enrolled in the MCO. The MCOs pay the SBHC from the MCO capitation paid by MassHealth. MassHealth's MCO contracts contain language requiring MCOs to coordinate with SBHCs.

Municipal Medicaid

Linkages are made between Municipal Medicaid providers and PCPs in the MCO Program. Special education-related services are paid for by either the municipality or the child's insurer, including MassHealth. The Commonwealth assures that schools involved in the Medicaid program for the delivery of Medicaid covered services to Special Education students who are MassHealth eligible will be required to coordinate service delivery plans with the child's primary care provider, including MCOs, where applicable.

Family Planning

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MassHealth members enrolled in an MCO may access Family Planning services provided by the MCO. However, such MCO enrollees may also receive Family Planning services from any Family Planning provider without consulting their PCP or MCO and are not required to obtain prior approval from MassHealth. For Family Planning services provided by MassHealth providers not participating in the MCO network, MassHealth reimburses the provider on a fee-for-service basis and recoups the funds from the MCO.

FQHCs

Currently, all but one MassHealth MCO (Fallon) contracts with at least one FQHC.

3.4.4 MCO Capitation Rates

Actuarially sound capitation rates will be established for all MCO's in accordance with 42 CFR 438 (the Balanced Budget Act regulations regarding Medicaid Managed Care). MassHealth's actuarially sound rates include the cost of all covered services, including covered diversionary services described in section 3.3.6. MCO contracts specify the requirements and rates relating to the different MCO-eligible MassHealth coverage types.

3.4.5 Behavioral Health/ Diversionary Services

MCO's provide a full range of behavioral health services, including covered diversionary services described in 3.3.6.

3.4.6 MCO Financial Performance

MassHealth monitors and evaluates the financial solvency, stability and expenditures of its MCOs annually and throughout the year through the collection and analysis of financial reports and insurance policies.

MCO Financial Reporting Requirements

MassHealth requires that each of its contracted MCOs submit quarterly and annual financial reports specific to its Medicaid business. These reports allow MassHealth to monitor and analyze cost, utilization and profitability trends for each MCO. In addition, MassHealth requires that MCOs submit to MassHealth copies of their quarterly and annual reports to the State's Division of Insurance. The submission of these reports allows the Commonwealth to calculate and analyze financial indicators that may act as "early warning signs" of financial instability or insolvency. These indicators include standard financial ratios related to the three key areas of financial performance, profitability, liquidity and capitalization.

Reinsurance and Insolvency Protection

MassHealth requires that each MCO maintain insurance policies to ensure adequate protection of enrollees against the risk of the financial liability or insolvency of the plan.

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MassHealth requires that MCOs submit annual copies of audited financial statements. Copies of audited financial statements are maintained by MassHealth. MassHealth's contract with the MCOs establishes that EOHHS has the ability to monitor and audit their financial submissions at any time.

3.5 Fee-for-Service Payments

Fee-for-service rates for any service provided to an eligible MassHealth member, are established either through contracts with MassHealth or through regulations promulgated by the Massachusetts Division of Health Care Finance and Policy. Any provider meeting the eligibility criteria set forth in MassHealth program regulations and provider agreements may participate in the MassHealth program. Service limitations and payment prerequisites are also specified in MassHealth program regulations and provider agreements.

3.6 Premium Assistance Payments

Premium assistance provides a premium assistance payment contribution toward the employee's share of the premium for an employer sponsored health insurance plan of which the member is a beneficiary or covered dependent, and which meets a basic benefit level.

3.6.1 Determining Whether Insurance Meets the Basic Benefit Level

MassHealth will utilize two methods for determining basic benefit level. Plans that have been preauthorized or certified will be maintained in an established database. Specifically, any health insurance product that meets the requirements of M.G.L. 176J (Massachusetts Small Group Health Insurance Reform Statute) will be deemed a qualified plan.

In order to become a qualified small group insurance plan in Massachusetts, the carrier or HMO must submit an evidence of coverage (subscriber agreement form) with the Division of Insurance (DOI). The DOI has the authority to approve or disapprove any small group product. On an annual basis, each carrier or HMO must submit an actuarial opinion certifying that the plan is in compliance with the rating requirements of M.G.L. 176J. A consumer complaint against a qualified small group insurance plan will generate an investigation by the Division of Insurance. If the DOI finds that the plan is out of compliance with M.G.L. 176J, the case is referred to the Market Conduct Board for further action.

The second method certifies self-insured and ERISA plans that do not match against the established database. These plans will be manually reviewed by a subsidy payment coordinator at MassHealth. The review will consist of a cost analysis of the deductible and co-payment schedule, a review of standard benefits (acute inpatient, outpatient, and physician services) and whether or not pharmacy benefits are included. Health benefit plans of self-insured or self-funded employers (ERISA plans) are not regulated by the DOI. To certify that an ERISA

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plan meets the requirements of the small group law, the employer will submit a copy of the subscriber agreement to MassHealth for review.

3.6.2 Enrollment

A member's eligibility for premium assistance will be effective on the first calendar day of the month following MassHealth's verification of the member's health insurance information. Premium assistance payments are for the following month's coverage.

3.6.3 Premium Assistance Payments

The payment of the premium will be subject to a cost-effectiveness test. If MassHealth determines that it is not cost-effective to pay the premium, the person may qualify for the purchase of medical benefits if eligible as described in sections 2.1.3 and 3.1. Payments will be monthly or quarterly. MassHealth will issue payments to the insurance company, employer or the member or policyholder covered by the health insurance.

3.6.3.1 Premium Assistance Payment Calculation

Once the applicant is found to be potentially eligible for a premium assistance payment, the premium assistance payment amount is calculated using the following information:

- The total health insurance premium;
- The employer share of the health insurance premium; and
- The MassHealth- calculated member share of the health insurance premium.

1. Estimated Premium Assistance Amount

The estimated premium assistance amount equals the total health insurance premium minus the employer share of the premium minus the MassHealth- calculated member share of the premium. For example, if the total monthly health insurance premium is \$500 and the employer is contributing 70% to the cost of the health insurance premium, then the current employee share is \$150 per month. For individuals and families with income over 100% FPL MassHealth will calculate a member share of the premium (see Family Assistance premium requirements in 2.1.3.4.6 and 2.1.4.10). If the MassHealth- calculated member share is \$30, then the MassHealth estimated premium assistance amount would be \$120 per month.

2. Maximum Premium Assistance Amount

The estimated premium assistance amount will then be compared to the maximum premium assistance amount per member. For families, the maximum premium assistance amount will be set at the average per member per month (pmpm) cost of a non-disabled individual multiplied

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by the number of eligible MassHealth members. The maximum premium assistance amount for adults will be based on the average cost of an individual, couple or family policy.

3. Actual Premium Assistance Amount

Once the estimated premium assistance amount has been compared to the maximum premium assistance amount, MassHealth will calculate an actual premium assistance amount.

- (a) If the estimated premium assistance amount is less than the sum of the maximum premium assistance amount per eligible member (as defined in #2 above), then MassHealth will set the actual premium assistance amount at the estimated premium assistance amount.
- (b) If the estimated premium assistance amount is higher than the sum of the maximum premium assistance amount per eligible member (as defined in #2 above), then MassHealth will set the actual premium assistance amount at the sum of the maximum premium assistance amount per eligible member amount. If it is determined that the remainder of the health insurance premium assistance program eligible family is greater than 5% of the family's gross income, then the family must enroll their children in the purchase of medical benefits.

3.6.3.2 Payment Process for Well Child/Co-Pays Above 5% Maximum

Consistent with Title XXI, and as described in **Section 2.1.3.4.6.1**, MassHealth will cover well child care in full and set a family cap on the amount of total cost sharing for previously uninsured families receiving Premium Assistance. MassHealth will cover cost sharing for well baby and well child care services by paying the provider or the family for any well child or well baby care co-payments and/or deductibles. Additionally, MassHealth will set a family cap on cost sharing at five percent of the family gross income. Once these families have incurred and paid bills on behalf of their children exceeding five percent of the family income, they will cease to be responsible for any additional co-payments or deductibles relative to their children's health care for that eligibility year.

After the eligibility determination is complete, MassHealth will notify the families of the cost sharing limits for both well childcare and expenses exceeding the family cap and the payment procedures. This notice will also include a definition of well childcare services. The five- percent cap will be calculated based on the gross family income used for the eligibility

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determination. Any cost sharing in the form of premiums will be deducted from that amount and the family will be notified of the amount of co-payments and deductibles for which they will be responsible.

MassHealth will make every effort to generate manual payments directly to the providers. Substantial number of providers are already on the state's vendor file, however, if the provider is not included on the state's vendor file, MassHealth will make the payment to the family and outreach to the provider. The outreach process will assure that the providers are given the opportunity to become a state vendor. To ensure that members are not required to pay the bill at the point of service, MassHealth will educate the provider community regarding the procedures for payment through bulletins and newsletters.

Consistent with MassHealth policies, after MassHealth notifies the family of the five percent cap it becomes the family's responsibility to track the expenditures and submit appropriate bills for payment. Once the family has incurred and paid out of pocket expenses totaling its family cap, the family will be required to submit proof of payment to a MassHealth representative who will review the submitted bills in a timely manner. The representative will review that the payments were made for the children and for health services covered by the family's policy. Once the review is complete, the family will be notified of the procedures for submitting all future bills to MassHealth. The family will be able to use this notification as documentation to show the provider. After the family cap has been reached, families will be directed to submit the provider co-payment or deductible bills to MassHealth for payment. MassHealth will review the bill and generate a payment to the provider or the member within one to two weeks of receiving the bill.

All aspects of subsidy payments to employers and employees through the MassHealth Insurance Partnership are addressed in **Section 11**.

4.0 Member Enrollment

4.1 Introduction

MassHealth uses an enrollment Broker (EB) to educate and enroll all managed care eligible MassHealth members in a health plan (MCO and PCC). The EB's major responsibilities include: educating potential members or their representatives about managed care plans, enrolling managed care eligible MassHealth members into a health care plan, providing customer service to the entire MassHealth population, and administering the non-emergency transportation program for all eligible MassHealth members.

4.2 Description of Enrollment Process

EBs enroll MassHealth managed care eligible members into a health plan under either the PCC plan or an MCO according to MassHealth policies, procedures, instructions and timeframes.

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The EB tracks and manages all systems activities necessary to enroll all managed care-eligible members. These activities include, but are not limited to, tracking those members who have received enrollment and outreach materials and ensuring timely mailing of appropriate outreach materials.

4.2.1 Receipt of Member Data

The EB receives data regarding managed care eligible members from MMIS. Eligibility workers at either the Department of Transitional Assistance (DTA) or MassHealth Operations determine MassHealth eligibility. The system then identifies members who meet managed care eligibility criteria and transmits this data to the EB for enrollment into a health plan.

4.2.2 Geographic Service Area

Geographic Service Areas are defined based on zip codes. Members are required to choose a health plan in their service area. If no satisfactory health plan is available in the member's service area, members may be allowed to select a health plan that is outside their service area.

There are three exceptions that allow members to enroll outside of their service area. These exceptions are:

1. The member has a language need that cannot be met by a health plan in his/her service area;
2. The travel time or distance to the requested out-of-area health plan is equal to or less than the travel time to get to a health plan within the member's service area; or
3. The medical benefit of receiving care from a health plan in the member's service area is substantially outweighed by the medical benefit of receiving care from the out-of-area health plan requested by the member.

If the member feels that there is a medical reason for enrolling outside the service area, the request must be clinically reviewed and approved by MassHealth. The EB must prepare the request for the member.

EBs inform members of their right to appeal the denial of any out-of-area enrollment request and send them a form to request a fair hearing.

4.2.3 Algorithm for Assignment to a Managed Care Provider

Certain MassHealth members have eligibility that requires managed care enrollment, as described in section 3.1. Required enrollees who do not choose a health plan within the fourteen- (14) calendar day time limit will be assigned to a health plan. (The term “assign” when used in this document refers to enrollment activities involving members who have not made an affirmative choice of a health plan). The assignment methodology takes into account the geographic location of the MCO and PCC plan providers relative to the member’s residence and MassHealth assigns members based on the rate at which a

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given health plan is selected in a given service area, compared to each of the other available plans as well as other factors such as quality performance and/or enrollment volume.

The assignment algorithm applies only to Standard, Family Assistance, and Basic, members who have not been determined to be disabled. MassHealth does not assign members who have been determined disabled to MCOs, but assigns them to a PCC based on disabling condition, geographic location, and, where possible, provider experience. (See Section 4.2.5.1)

Essential members who do not choose a PCC within prescribed timeframes will be assigned using an algorithm in which MassHealth will first attempt to automatically assign members to Community Health Centers, including Hospital Licensed Health Centers, where available. Essential members can subsequently transfer to another PCC within their geographic service area at any time for any reason.

4.2.4 Manual Assignments

Manual assignments are done by EBs and occur when the system is unable to make a zip code, city/town or service area match between the member and an available health plan. Manual assignments, like automatic assignments, are made based on geography and voluntary selection rates.

Additionally, any member who loses and then within 1 year regains managed care eligibility may be automatically re-enrolled with the health plan with which the member was most recently enrolled.

4.2.5 Enrolling Special Populations

4.2.5.1 Persons Who Have Been Determined Disabled

Persons who have been determined disabled may choose an MCO. However, MassHealth does not assign persons who have been determined disabled to MCOs. Instead, MassHealth assigns persons who have been determined disabled to a PCC, taking into consideration the special needs arising from the member's disabling condition.

4.2.5.2 Hemophilia and Other Bleeding Disorders

Medicaid requires that all MassHealth participants with bleeding disorders, who are not enrolled in a MCO, obtain their Anti-Hemophilia Factor ("AHF") drugs from a single provider. All such members are encouraged to utilize the services of this single provider's representatives, including their pharmacy team, pharmacy care coordinators, community advocates, and nursing staff to the extent deemed appropriate by Medicaid. The single provider's representatives are available to coordinate with the member's PCC, PCP or primary care doctor and Hemophilia Treatment Centers to optimize therapy outcomes and to ensure the cost-effective use of AHF drugs

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4.2.6 Transfer Policy

MassHealth does not have a lock-in policy. Members who either choose or are assigned to a health plan may transfer to another available health plan in their geographic service area at any time for any reason. The transfer process begins when the member calls the Customer Service Center toll free number and requests a transfer. An EB helps the member identify a new health plan in his or her service area. The only restrictions are that: (1) the health plan must be in the members' geographic service area; (2) the members' request must meet the time and distance guidelines described in section 4.2.2; or (3) the member must request and receive approval for an out-of-area transfer as described in section 4.2.2.

4.2.6.1 Member-Initiated Transfers

The member-initiated transfer process for members begins when the member calls the Customer Service Center toll free number and requests a transfer. An EB helps the member identify a new health plan in his or her service area. The transfer is processed by the EB within twenty-four (24) hours.

4.2.6.2 MassHealth-Initiated Transfers

MassHealth may initiate the transfer of a member based on provider capacity, or if a health plan or primary care clinician terminates its agreement with MassHealth. When MassHealth-initiated transfers are required, MassHealth contacts the members to select a new health plan in their service area.

4.3 Managed Care Enrollment Requirements by Coverage Type

Eligibility for all MassHealth coverage types is described in section 2.1. Covered Services and Delivery Systems Options for each coverage type are described in section 3.1.

4.3.1 Demonstration-Eligibles Who are not Required to Enroll in MassHealth Managed Care

MassHealth members listed below are not required to enroll in a MassHealth managed care plan:

- A member for whom Medical Assistance is a secondary payer (i.e., a member with other health insurance. For purposes of exclusion from a health plan, "other health insurance" is defined as any medical coverage plan available to the member, including, but not limited to, Medicare, CHAMPUS, or a managed care organization.);
- Certain members who are receiving MassHealth Standard, CommonHealth, or Family Assistance benefits during the presumptive eligibility period or the time-limited period while MassHealth investigates and verifies access to cost-effective private health insurance that meets the basic benefit level or the time-limited period while the member is enrolling in such insurance;
- MassHealth Prenatal and Limited members may not enroll in MassHealth managed care;

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- A MassHealth Standard member who is receiving hospice care, or who is terminally ill as documented with a medical prognosis of a life expectancy of six (6) months or less.

4.3.2 Managed Care Requirements for Standard Members

Standard members below **MUST** enroll in managed care:

- All MassHealth Standard members in the Demonstration Project who are not listed in 4.3.1 or 4.3.6 must enroll with either a MassHealth contracted Managed Care Organization (MCO) or in the Primary Care Clinician (PCC) plan. Women with breast or cervical cancer may only enroll in the PCC Plan.
- During any period a managed care eligible Standard member is not enrolled in a managed care plan; such member will receive services, including Mental Health and Substance Abuse (MH/SA) services, from any MassHealth provider on a fee-for – service basis.

4.3.3 Managed Care Requirement for Basic members

In order to receive services, all Basic members who are eligible for purchase of medical benefits by MassHealth must enroll in either the MCO or PCC plan.

4.3.4 Managed Care Requirement for Essential members

In order to receive services, all Essential members who are eligible for purchase of medical benefits by MassHealth must enroll with a PCC

4.3.5 Managed Care Requirement for Family Assistance members

4.3.5.1 Family Assistance children, who do not have access to employer-sponsored health insurance, must enroll in either the MCO or PCC plan. During any period an eligible Family Assistance member is not yet enrolled in a managed care plan, such member will receive Mental Health and Substance Abuse (MH/SA) services and all other covered services on a fee for service basis from any MassHealth provider.

4.3.5.2 All MassHealth Family Assistance members with HIV disease who are not enrolled in private health insurance must participate in the Primary Care Clinician (PCC) plan. During any period an eligible Family Assistance member is not yet enrolled in the PCC plan, such member will receive Mental Health and Substance Abuse (MH/SA) services, and all other covered services on a fee for service basis from any MassHealth provider.

4.3.6 Members Who May Voluntarily Participate in MassHealth Managed Care

4.3.6.1 CommonHealth

CommonHealth members, who are not excluded under section 4.3.1, may choose to enroll in the MCO or PCC plan. CommonHealth members who do not choose to enroll in MassHealth managed care may receive benefits on a fee-for service basis.

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4.3.6.2 Children in the Care or Custody of Department of Social Services or Department of Youth Services

Standard eligible children who are in the care or custody of DSS or DYS may receive non-behavioral health services on a fee-for-service basis or choose to enroll in the MCO or PCC plan. All children in the care of DSS or DYS who are not enrolled in the MCO plan must receive behavioral health services from the BHP contractor.

4.3.6.3 Family Assistance Members with HIV

Family Assistance Members with HIV who have access to employer-sponsored health insurance may choose the employer-sponsored insurance or enroll in the PCC plan.

4.4 Reporting

This section describes how enrollments to participating health plans will be tracked and recorded. Reports are printed as separate listings for the Behavioral Health Plan (BHP), the PCC Plan, and the MCO Program. The system is geared to track current managed care enrollment on a thirty (30) calendar day snapshot basis and break enrollment down in a variety of ways.

For the PCC Plan and the MCO Programs, an additional feature has been added to track the activity in these programs within the thirty (30) calendar days between the current snapshot and the prior month snapshot.

4.4.1 Tracking Managed Care Enrollments and Monitoring Assignment Rates

The following are the types of enrollment information captured and produced on each report and broken out by benefit plan (*i.e.*, BHP, MCO, PCC):

BHP:

- Case head count of enrollments in progress;
- Entire population of members;
- Entire population of members by category of assistance (COA), age, and race; and
- Entire population of members by COA, age, and language.

MCOs:

- Entire population of members;
- Provider panel sizes;
- Entire population of members by CO, age, and race;
- Entire population of members by COA, age, and language;
- Entire population of members by plan, age, and language;
- MCO activity; enrollment into and disenrollment from coverage types;
- Provider disenrollment by reason;
- Total number and percent of members who self-select, are batch assigned, manually assigned, or auto-reenrolled;

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- Striation of length of time it takes a member to choose;
- Transfer rates of members moving from one plan to another, broken down by health plan; and
- Number of members who upgrade and downgrade between coverage types.

PCCs

- Entire population of members;
- Entire population of members by PCC type;
- PCC panel sizes;
- Entire population of members by COA, age, and race;
- Entire population of members by COA, age, and language;
- Activity by PCC; enrollment into and disenrollment from the PCC;
- PCC disenrollment by reason;
- Total number and percent of member who self-select, are batch assigned, manually assigned, or auto-reenrolled;
- Striation of length of time it takes a member to choose;
- Transfer rates of members moving from one plan to another, broken down by health plan; and
- Number of member who upgrade and downgrade between coverage types

4.4.2 Automatic Versus Voluntary Enrollment Rates

MassHealth tracks automatic (*i.e.*, assigned) and voluntary enrollment rates. The current standards for rates of automatic and voluntary enrollments are based on past performance rates. MassHealth's target choice rate range is between 75% and 85%.

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6.0 Quality Assurance

6.1 Managed Care Quality Assurance

42 CFR 438 Subpart D sets forth specifications for quality assessment and performance improvement strategies that must be implemented to ensure the delivery of quality health care by all MCO's, PIHP's and PAHP's. MassHealth will prepare, submit and implement a quality strategy plan for all MassHealth contracted MCO's and the BHP contractor pursuant to the requirements set forth. MassHealth also anticipates including its PCC plan in this quality strategy, even though MassHealth is not specifically required to do so by BBA regulations.

6.2 Fee-For-Service

The fee-for-service program, also known as the indemnity program, is managed by MassHealth.

The Acute Hospital program utilizes two basic vehicles for managing and monitoring program quality.

- Acute Hospital Quality Initiative; and
- Acute Hospital utilization Management Program.

6.2.1 Acute Hospital Quality Initiative

As a condition of participation with all fee-for-service plans as well as the PCC Plan, acute hospitals must meet the requirements specified in the Acute Hospital provider agreement, including the Acute Hospital Quality initiative.

6.2.2 Hospital utilization Management Program

MassHealth, through a contractor, operates an extensive utilization management program for all contracted acute hospitals. All acute hospitals must participate in the utilization management program. The program consists of utilization review programs, quality improvement projects, and other types of programs.

6.2.2.1 Utilization Review Programs (includes preadmission screening, concurrent review, prepayment review, postpayment review, retrospective procedure review).

This program ensures the medical necessity of hospital admissions and visits, and reviews the quality of care provided. For preadmission screening and concurrent review, MassHealth requires telephone reviews to determine medical necessity. For prepayment, postpayment, and retrospective review, MassHealth's contractor conducts a sample of medical record reviews to determine medical necessity and deficiencies in quality of care. Medical necessity and quality of care are compared against clinical standards.

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6.2.2.2 Quality Improvement Projects

Projects are designed to increase hospital compliance with clinical standards of care. Masshealth's contractor gathers hospital data through record review and other analytic means in order to assist hospitals to achieve individual goals of improved care. They conduct educational sessions to share information. Outcomes are measured via project-specific clinical indicators gathered primarily from medical record review.

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8.0 [Section 8 Reserved]

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9.0 Requirements for Budget Neutrality Reporting to CMS

9.1 Ongoing Evaluation

9.2 Program Amendments

9.2.1 At a minimum, the following information must be provided for each program amendment proposed by the Commonwealth:

- Current “with” and “without” waiver status on both summary and detailed level through the current approval period using the most recent actual expenditures.
- Summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, isolating (by MEG) the impact of the amendment and clearly indicating such on the documentation submitted.

9.2.2 Any proposed amendments to the demonstration may not result in a reduction of the Commonwealth’s budget neutrality cushion below 0.

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10.0 Administrative Confirmations

MassHealth (EOHHS) acknowledges its responsibility to comply with all the special terms and conditions of the Demonstration Project. MassHealth will provide documentation and reports as required and requested by CMS that are necessary for proper administration of the Demonstration Project. If MassHealth wishes to make changes in the Demonstration, MassHealth will submit those changes to CMS in accordance with term and condition #4.

10.1 Promulgating Regulations

10.1.1 Non-emergency Regulations

The following describes the steps for promulgating non-emergency regulations pursuant to the State Administrative Procedures Act:

- a) Send a copy of draft regulations to Executive Office for Administration and Finance (EOAF) for review and approval. By Executive Order, this must be done at least two weeks before public notice.
- b) Public notice: one-day advertisement in a newspaper of general circulation of a notice that summarizes changes and tells readers where to call for a copy of draft, where to submit comments, and when comments are due. Advertisements must also appear in the Massachusetts Register at least one week before agency action.
3. Finalize draft: incorporate any appropriate comments from public notice.
4. Send "Final summary" form to EOAF to summarize any changes since public notice. Must be done at least one week before promulgation
5. File regulations with Secretary of State. Must file at least two weeks before issue of Massachusetts Register that is published on or before the effective date of regulations. (That is: Register is published every two weeks; deadline for each issue is two weeks before its publication date.)
6. Print and mail regulations to users.

10.1.2 Emergency Regulations

The following describes the steps for promulgating emergency regulations pursuant to the State Administrative procedures Act:

1. Send a copy of draft regulations to Executive Office for Administration and Finance (EOAF) for review and approval. By Executive order, this must be done at least two weeks before promulgation, but can be shorter turnaround if needed.

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2. File regulations with Secretary of State. Must be filed on or before the effective date of regulations.
3. Print and mail regulations to users
4. Public notice: one-day advertisement in a newspaper of general circulation of a notice that summarizes changes and tells readers where to call for a copy of draft, where to submit comments, and when comments are due. For an emergency, you have 90 days from date you file regulations to hold public notice and finalize draft.
5. Send “Final Summary” form to EOAF to summarize any changes since public notice. Must be done at least one week before final agency action (**see next step**).
6. If no changes since emergency regulations originally filed, file a “Notice of Compliance” with Secretary of State within 90 days from date emergency regulations originally filed. Original regulations remain in effect, with original effective date. If changes, refile revised regulations with Secretary of State (they’ll supersede original regulations; effective date will be date they appear in Register or a later date, but can’t be later than end of 90 days, or original regulations will have expired). Must be done in time so they appear in Register published on or before end of 90 days (**see step 4**).
7. Print and mail revised regulations to users.

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Insurance Partnership Program

Operational Procedures for Insurance Partnership and Family Assistance Premium Assistance

11.0 Introduction

This section describes the procedures and requirements needed for premium assistance and Insurance Partnership under the IP. MassHealth contracts with several administrative entities to market the IP, to provide customer service to qualified employers and their employees, and to administer the premium assistance and Insurance Partnership payments on their behalf. These administrative entities are Billing and Enrollment Intermediaries (BEIs) and the Insurance Partnership Agent (IPA).

To qualify as an approved BEI, an organization must meet the criteria of 211 CMR 66.13(3), including being registered with the Commonwealth of Massachusetts Division of Insurance as a BEI and comply with MassHealth's contract requirements. The IPA is an entity that contracts directly with MassHealth to perform IP-related functions.

Functions of the IP administrative entities:

BEI and IPA functions overlap to some extent, although they serve different groups of employers and perform distinct roles within the IP. Both BEIs and the IPA market the IP to employers, insurers, health insurance intermediaries, and other entities involved in obtaining health coverage for employers and employees. BEIs and the IPA assist in enrolling eligible employers and employees into IP. BEIs and the IPA also provide qualified employers and eligible employees with customer service.

The roles of BEIs and the IPA diverge in terms of health plan enrollment and the health insurance payment process. Generally, BEIs formally enroll employer groups in health plans and bill employers for premiums. The IPA serves those employers not affiliated with BEIs or BEI-linked entities. It qualifies employers for the IP and allows employers to enroll in and purchase health plans through a broker of their choice (or directly through the insurer). Distinctions between the BEI and IPA approach to the IP payment process are described in **Section 11.5** below.

11.1 Overview

MassHealth makes premium assistance payments available to all members with a gross family income at or below 200% of the FPL, who have access to qualifying employer-sponsored health insurance. A qualified employer-sponsored health insurance plan must meet the Basic Benefit Level and the employer must contribute at least 50% toward the premium. This design creates an overlap

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between the Insurance Partnership, Standard premium assistance, CommonHealth premium assistance, and MassHealth's Title XXI State Plan. Effective October 1, 2006, eligibility for the IP will expand to include members with gross family income at or below 300% of the FPL.

There are three MassHealth coverage types through which members may receive premium assistance towards their employer-sponsored health insurance – Standard, CommonHealth, and Family Assistance.

The Insurance Partnership Program has two components: assisting employers with their health insurance costs through an Insurance Partnership payment and assisting employees with payment of health insurance premiums through a premium assistance payment. The Insurance Partnership payment is based on amounts fixed by state legislation and the payment process is described in **Section 11.5** and the premium assistance payment calculation is described in **Section 3.6**. Effective October 1, 2006, individual subsidies to IP members will be limited to the value of the subsidies specified for the Commonwealth Care Health Insurance Program.

Qualified employers will receive Insurance Partnership payments for each MassHealth member who receives premium assistance from MassHealth, no matter which MassHealth coverage type the member receives. All premium assistance payments made on behalf of MassHealth eligible members are eligible for FFP at the appropriate federal matching rate (except for those made on behalf of children under age 19 who are Aliens with Special Status as described in **Section 2.1.2.1.3**) as well as Insurance Partnership payments for “new” employer offered health insurance. New insurance is insurance that was not offered prior to January 1, 1999. Insurance Partnership payments for continuing and upgraded employer sponsored health insurance will be state funded.

MassHealth determines eligibility for premium assistance payments as described in Section 2. The payment process is described below:

Members eligible for Standard or CommonHealth as well as Family Assistance members with HIV disease receive premium assistance through the Premium Assistance program. MassHealth provides premium assistance towards all or part of a member's private health insurance when it is cost-effective for MassHealth to do so. Some of these members will be claimed under Title XXI provided they (1) fall within an expansion category, (2) they are newly insured, (3) their health insurance meets the Basic Benefit Level (as described in section 3.6), and (4) their employer contributes at least 50% toward the cost of the health insurance policy.

Family Assistance members described in **Sections 2.1.3.4.6.1, 2.1.3.4.6.2, and 2.1.3.4.6.3** receive premium assistance through either the IP or under Title XXI. In order for children to be eligible for Family Assistance, they must have a family

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group gross income that is greater than 150% of the FPL but not greater than 200% of the FPL. Children with access to employer-sponsored health insurance (uninsured at the time of application) meeting the basic benefit level receive premium assistance through Title XXI. Children who are already insured at the time an application is made to MassHealth receive premium assistance through the IP as long as the employer contributes at least 50% to the cost of the health insurance premium and the insurance offered meets the basic benefit level. Family Assistance eligible members whose family's gross monthly income is between 100 and 150 percent of the federal poverty level will be charged a premium of \$12 per child, up to a maximum of \$15 per family group. Family Assistance eligible members whose family's gross monthly income is between 150 and 200 percent of the federal poverty level will be charged a premium of \$12 per child, up to a maximum of \$36 per family group.

Parents of children eligible for Family Assistance may be eligible themselves for Family Assistance if they work for a qualified employer. However, the premium assistance payments and FFP will be based on the children's eligibility.

Adults without children may be eligible for Family Assistance only if they work for a qualified small employer and they purchase employer-sponsored health insurance. These adults receive their premium assistance through the IP. In order for adults without children to be eligible for Family Assistance, they must have a family group gross income less than or equal to 200% of the FPL (effective October 1, 2006, less than or equal to 300% FPL). Those members whose family group gross income is at or below 100% of the FPL will not have to pay anything towards the cost of their employer-sponsored health insurance. Family Assistance eligible members whose family's gross monthly income is between 100 and 200 percent of the federal poverty level will be charged a premium of \$27 per childless adult, up to a maximum of \$54 per couple. Premiums for members between 200 and 300 percent FPL are currently under development.

11.2 Employer Marketing

The IP administrative entities (BEIs and the IPA) are responsible for marketing of the IP program to employers. They will target those employers who offer or seek to offer health insurance to their employees as well as new businesses as they enter the marketplace. MassHealth will target its marketing and advertising activities toward potential MassHealth members. However, the IPA is also responsible for developing and implementing a statewide advertising campaign that promotes the IP to the target employee population.

The BEIs and IPA will work cooperatively with MassHealth to plan, develop and implement all marketing materials. All marketing materials require MassHealth approval prior to production and distribution. The administrative entities will inform employers of upcoming changes in the program through the development

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and production of ongoing communication materials. These draft communication materials require MassHealth approval.

11.3 Employer Enrollment

The IP administrative entities will enroll employers qualified for Insurance Partnership payment based on MassHealth's program criteria. The IP enrollment process begins with BEI and IPA outreach to potentially qualified employers. These employers will have been identified through marketing efforts (see Section 11.2) or by MassHealth. The employers will be provided with an "Enrollment Package" containing an Insurance Partnership Employer Application by mail, telephone, or in a sales meeting. The BEIs and IPA will review all employer enrollment forms to determine an employer's qualification for the Insurance Partnership. Employers will be informed of their eligibility status in a written notice from the IP administrative entities, which will report the results of employer determinations along with associated employer data to MassHealth.

11.3.1 Change in Employer Data

Qualified employers are required to complete another application upon change of ownership, federal employer identification number (FEIN), address, percentage of the contribution amount, or when any other circumstances change that might impact their qualification for the program. Qualified employers do not need to complete another application unless one of these events occurs, and otherwise continue in their active status. The IP administrative entities are responsible for this process. The BEIs and IPA will review the information to determine if the employer continues to meet the employer eligibility criteria. They will then inform both MassHealth and the employer of the employer's current eligibility status by written notice.

11.3.1.1 Employer Data Base

MassHealth will establish and maintain an employer database to include all qualified employer information. This information will include the employer's name, address, telephone number, SSN or FEIN, employer premium contribution amount and health insurance information (including plan offered, tiers of coverage offered and date health insurance was offered). The IP administrative entities are required to contribute to the maintenance of the employer database, preferably on a daily basis. The information will be obtained from the employer through the enrollment process or through routine notification by the employer of a change. Employer information obtained by Masshealth's health insurance identification and investigation vendor will be coordinated with information obtained by the BEIs and IPA. Changes in employer information will be used to reassess member eligibility for premium assistance or to adjust the premium assistance or Insurance Partnership payment amount.

11.4 Employer and Employee Customer Service

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11.4.1 Employer Customer Service

The IP administrative entities will provide customer service for employers by communicating all information regarding the IP. They will also assist all potential employers in the MassHealth IP enrollment process. This includes providing assistance with the completion of employer enrollment. Further, the BEIs and IPA will respond to all employer inquiries about their eligibility status, premium assistance payments and Insurance Partnership payments.

As part of their customer service responsibilities, these administrative entities will ensure that qualified employers are informed of upcoming changes in policy or procedures and share best practices through development of newsletters, fact sheets and other materials.

11.4.2 Employee Customer Service

The IP administrative entities are responsible for addressing all inquiries made by employees regarding MassHealth Premium Assistance and the status of a premium assistance payments.

They will refer all employee inquiries related to MassHealth eligibility, premium assistance amounts and availability of health insurance to the appropriate MassHealth Customer Service Center.

11.4.3 Other Customer Service Functions

The IPA will also provide customer service to insurers as well as business organizations, brokers, and other entities involved in obtaining health coverage for employer groups. This customer service will include (but is not limited to) responding to inquiries about the Insurance Partnership and providing informational materials about the program.

11.5 Health Insurance Payments

11.5.1 Payment Process

The BEIs and the IPA will manage the premium assistance and Insurance Partnership payments in different ways. The following describes MassHealth's procedures in each case for making the premium assistance and Insurance Partnership payments, which offset the employee and employer health insurance premiums:

The BEI Process

The BEIs perform the following Insurance Partnership payment functions:

- The BEI determines an employer to be qualified to receive Insurance Partnership payments according to MassHealth criteria

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- The BEI will receive from MassHealth a list, on a monthly basis, sorted by qualified employer, which is obtained from both information on MA21 and the employer database, and includes: Members/employees eligible for premium assistance, their premium assistance amount, associated Insurance Partnership amount, and the total Insurance Partnership amount for the employer.

MassHealth will deposit in the BEI's bank account the total amount of premium assistance and Insurance Partnership payments to be given to the Insurers on behalf of the qualified employers and eligible employees, and the administrative compensation owed the BEI. This payment will be based upon the monthly list described above, and will be made before the beginning of the coverage month. The BEI will indicate on the total monthly health insurance bill, which it sends to employers, the amount of payment, which will be contributed by MassHealth. In effect, the amount due for health insurance will be reduced for an employee eligible for premium assistance, by the employer's Insurance Partnership payment (employee's premium assistance payment and the employer's incentive payment).

- The BEI will withdraw MassHealth's contribution amount from the bank account and pay the health insurance, once the BEI receives the payment from the employer for that month's health insurance premium
- The BEI will support the accuracy of all payments by updating MassHealth's employer database with information obtained through the employer enrollment process. This information includes both demographic information about the employer (e.g., name, address, FEIN) and health insurance information (e.g., health insurance tiers offered, employer and employee contribution amounts, date health insurance first offered by tier). The BEI will also notify MassHealth of any known changes that potentially affect an employee's eligibility (i.e. birth of child, divorce, loss of employment).
- A monthly reconciliation process will occur to ensure the accuracy of these premium assistance and Insurance Partnership payments.

The IPA Process

The Insurance Partnership Agent (IPA) will perform the following Insurance Partnership payment functions for employers not served by BEIs or BEI-linked entities:

The IPA determines, based on MassHealth criteria, which employers are qualified for the Insurance Partnership. The IPA continually updates MassHealth's systems with information and changes regarding qualified employers;

- MassHealth provides the IPA with a comprehensive monthly data file of qualified employers, eligible employees, and their corresponding

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Insurance Partnership and premium assistance payments, sorted by employer.

- MassHealth deposits in the IPA's bank account the total amount of premium assistance and Insurance Partnership payments.
- Based on the data file, the IPA creates a check for each qualified employer, indicating each employer's Insurance Partnership payment and their employees' corresponding premium assistance payment. the IPA will then:
 - (a) Provide the check and accompanying remittance advice to qualifying employers;
 - (b) Require qualified employers to use such monies towards their Employees' health insurance premiums;
 - (c) Require employers to provide necessary corrections or confirmations to the remittance advice. The IPA will then share this information with MassHealth;
- The IPA will audit and reconcile the premium assistance and Insurance Partnership payments on a regular basis and report to MassHealth on the payments and any reconciliation efforts.
- The IPA is responsible to ensure that the employee's withhold is properly adjusted and the employer continues to purchase health insurance for the employee.

11.6 Employer Regulations

MassHealth has developed a set of employer regulations which govern the responsibilities of qualified employers, the BEIs, and the IPA. **(See Attachment 11.2)**

11.7 Expanded Future FFP

MassHealth worked cooperatively with Research Triangle Institute (RTI) International, a firm hired by CMS to do an analysis of Insurance Partnership program development and implementation. As part of that process, RTI conducted an independent survey of participating and non-participating Massachusetts eligible employers to determine the impact of the IP program on the marketplace. Massachusetts will work with CMS to use this analysis in considerations of extending FFP to employer subsidies for employers offering continued and improved employer-provided health insurance. From the RTI report and other considerations, such as budget neutrality and comparisons of Massachusetts' experience with regional and national trends, CMS will make a determination within 90 days of receiving the RTI report.

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Safety Net Care Pool Payment Methodologies

I. Background

The Safety Net Care Pool (SNCP) was implemented on July 1, 2005, the first year of the demonstration's three-year extension period. SNCP payments are capped for demonstration years 9, 10 and 11. The amount of the cap for each year is equal to the SFY 2005 supplemental payments to two safety net providers plus the state's annual DSH allotment previously reimbursed under the authority of the State Plan. The SFY supplemental payments were \$770 million and the DSH allotment is \$574.5 million. The total amount for the SNCP is \$1.34 billion per year.

For the period July 1, 2005 through June 30, 2006 (SFY 2006), the Special Terms and Conditions under which the demonstration was extended authorizes SNCP payments to be made to the Boston Public Health Commission and Cambridge Public Health Commission in the same manner as they had been for the first eight years of the demonstration, and authorizes the former DSH payments to be made out of the SNCP. As such, the DSH payment methodologies in the state plan were amended to reflect their status as SNCP payments. CMS has since requested that the state remove these former DSH payment methods from the Medicaid state plan effective October 1, 2005. The Commonwealth has continued to make these former DSH payments using the same reimbursement methodologies that had been approved by CMS for hospital rate year 2005 (beginning October 1, 2004). Therefore, the former DSH payment methodologies are included in this Attachment as SNCP payments. Updates to these SNCP payment methodologies will be made as needed.

II. Overview of Document

This Attachment describes methodologies for four distinct types of payments that will be made from the Safety Net Care Pool (SNCP). The payment methodologies pertain to acute hospital payments, non-acute hospital payments, Commonwealth Care Health Insurance Program (CCHIP) premium assistance payments, and payments for costs related to individuals residing in an Institution for Mental Disease (IMD).

These payment methodologies have been separated into methodologies for State Fiscal Year (SFY) 2006, the first year of the demonstration extension period, and methodologies for SFY 2007. The state will submit amended SNCP payment methodologies for SFY 2008 as needed.

The SFY 2006 methodologies continue the former disproportionate share hospital (DSH) methodologies contained in the approved state plan, and are included in this Attachment as SNCP payments. Updates to these SNCP payment methodologies will be made as needed.

For SFY 2007, which begins July 1, 2006, new payment methodologies are included to reflect additional SNCP payments for new supplemental acute hospital payments, CCHIP

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premium assistance payments, and payments for costs related to individuals residing in an IMD.

III. State Fiscal Year 2006 SNCP Payment Methodologies

A. Acute Hospital Payment Methodologies

MassHealth will assist Hospitals that carry a financial burden of caring for uninsured and publicly insured persons of the Commonwealth. In accordance with the terms and conditions of the Commonwealth's section 1115 demonstration governing Safety Net Care, and subject to compliance with all applicable federal requirements, MassHealth will make an additional payment above the state plan rate to Hospitals which qualify for such payment under any one or more of the classifications listed below. Only Hospitals that have an executed Contract with the Executive Office of Health and Human Services (EOHHS), pursuant to the Acute Hospital Request for Applications (RFA), are eligible for the following safety net care payments.

If a Hospital's RFA Contract is terminated, its payment shall be prorated for the portion of the year during which it had a Contract with EOHHS. The remaining funds it would have received shall be apportioned to remaining eligible Hospitals. The following describes how Hospitals will qualify for each type of safety net care payment and the methodology for calculating those payments.

When a Hospital applies to participate in MassHealth, its eligibility and the amount of the following safety net care payments shall be determined. As new Hospitals apply to become MassHealth providers, they may qualify for such payments if they meet the criteria under one or more of the following classifications. Therefore, some safety net care payments may require recalculation. Hospitals will be informed if the payment amount will change due to reapportionment among the qualified group and will be told how overpayments or underpayments by EOHHS will be handled at that time.

All Safety Net Care payments are subject to the availability of federal financial participation.

1. **High Public Payer Hospital Safety Net Care Payment (114.1 CMR 36.07)**

a. Description

- i. The High Public Payer Hospital payment is for hospitals that have the highest percentages of revenue from Medicare, Medicaid, other government payers, and free care, relative to their total revenue.

b. Eligibility

- i. The Massachusetts Division of Health Care Finance and Policy (DHCFP) determines the percentage of each hospital's gross patient

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service revenue (GPSR) that is attributable to Medicare, Medicaid, other governmental payers, and free care.

1. Data for this calculation comes from the DHCFP-403 Cost Report and the Uncompensated Care (UC)-Form filing. For the purposes of this calculation, Medicare managed care GPSR is included as Medicare GPSR, and Medicaid managed care GPSR as Medicaid GPSR.
 2. If this percentage is greater than or equal to 63%, the hospital qualifies as a Disproportionate Share Hospital, as defined by state statute, and may be eligible for a High Public Payer Hospital payment.
- ii. DHCFP then calculates, for each state-defined Disproportionate Share Hospital, the ratio of its allowable free care charges, as defined below, to total charges. Free care charge data comes from the UC-Form filing (included at the end of Attachment E).
 1. Definition of allowable free care charges (MGL c. 118G, Section 1): “Free care”, the following medically necessary services provided to individuals determined to be financially unable to pay for their care, in whole or in part, pursuant to applicable regulations of the division: (1) emergency, urgent, and critical access services provided by acute hospitals; (2) services provided by community health centers; and (3) patients in situations of medical hardship in which major expenditures for health care have depleted or can reasonably be expected to deplete the financial resources of the individual to the extent that medical services cannot be paid, as determined by regulations of the division.
 - iii. DHCFP ranks the eligible hospitals from highest to lowest by the ratio of allowable free care charges to total charges, and determines the 75th percentile of the ratios. Hospitals that meet or exceed the 75th percentile qualify for a High Public Payer Hospital payment.
 - iv. Based on the eligibility criteria, Boston Medical Center, Brockton Hospital, Cambridge Health Alliance, Clinton Hospital and Lawrence General Hospital are the only hospitals eligible for this payment.
- c. Calculation
- i. The General Court appropriates \$11.7 million for this payment
 - ii. DHCFP multiplies each High Public Payer Hospital’s allowable free care charges by the hospital’s most recent total cost to charge ratio to determine allowable free care costs.
 1. The total cost to charge ratio, calculated by DHCFP, is the sum of each hospital's inpatient reasonable costs and actual outpatient costs, divided by the hospital's GPSR. To

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determine reasonable inpatient costs, DHCFP compares the hospital's actual inpatient cost per discharge (adjusted for case-mix and wage variations) to a statewide efficiency standard. The efficiency standard is the statewide weighted mean cost per discharge. If the hospital's cost per discharge exceeds this standard, the hospital's costs are capped at the standard. If the hospital's cost per discharge is below the standard, the hospital's actual costs are allowed. The allowable amounts are then readjusted for case-mix and wage area and multiplied by discharges. Data for this calculation comes from the DHCFP-403 Cost Report.

- iii. DHCFP sums all allowable free care costs for High Public Payer Hospitals.
- iv. Each High Public Payer Hospital's payment is equal to each hospital's share of all allowable free care costs by High Public Payer Hospitals, multiplied by the total appropriation for this payment.

2. Public Service Hospital Safety Net Care Payment (114.1 CMR 36.07)

a. Description

- i. The Public Service Hospital Safety Net Care Payment is for safety net hospitals that have significant free care charges, and a disproportionately public payer mix.

b. Eligibility

- i. DHCFP determines the percentage of each hospital's GPSR that is attributable to private sector payers and free care.
 - 1. In order to be eligible for this payment, a hospital must be a public hospital or a public service hospital. Public service hospitals are defined as any public acute hospital or any acute hospital operating pursuant to Chapter 147 of the Acts & Resolves of 1995 with less than 35% of GPSR from private sector payers and more than 20% of GPSR for uncompensated care.
- ii. DHCFP then calculates each public or public service hospital's Medicaid and free care charges for FY03, or for any new hospital, for a base year as determined by DHCFP; to be eligible for this payment, these charges must be at least 15% of total charges for FY03 or the base year.
- iii. Additionally, to be eligible for this payment, a hospital must be an essential safety-net provider in its service area, as demonstrated by delivery of services to populations with special needs including persons with AIDS, trauma victims, high-risk neonates, or indigent or uninsured patients.

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- iv. Based on the eligibility criteria, Boston Medical Center and Cambridge Health Alliance are the only hospitals eligible for this payment.
 - c. Calculation
 - i. For FY06, this payment will be \$52,000,000 for Boston Medical Center and \$51,500,000 for Cambridge Health Alliance, provided that the hospitals submit sufficient documentation to support these payments.
- 3. Uncompensated Care Safety Net Care Payment (114.6 CMR 11.00)**
- a. Description
 - i. The Uncompensated Care Safety Net Care Payment is for acute hospitals that incur uncompensated costs for services to low-income patients.
 - b. Eligibility
 - i. All acute hospitals that have free care costs for services to low-income patients are eligible for this payment.
 - c. Calculation
 - i. DHCFP allocates funds for hospital uncompensated care.
 - ii. DHCFP calculates the Total Low Income Patient Care Costs for each hospital by using the most recent 12 months of hospital low-income charge data, applying separate inpatient and outpatient cost to charge ratios to determine allowable free care costs, and trending this base period forward to the current fiscal year using 7.6% per year, which is the average growth rate for FY99-FY03 weighted inpatient and outpatient costs.
 - 1. Each hospital reports Charges for Eligible Services to Low Income Patients on the UC-Form, submitted monthly and backed up with claims.
 - 2. DHCFP multiplies each hospital's Charges for Eligible Services to Low Income Patients for the base period by the hospital's most recent inpatient- and outpatient-specific cost to charge ratios to determine the Total Low Income Patient Care Costs for the base period. For pool fiscal year 2006 (October 1, 2005-September 30, 2006), the most recent data is from HFY 2004. For the upcoming pool fiscal year 2007, it will be HFY 2005.
 - a. The specific cost to charge ratio (both the inpatient and outpatient cost to charge ratio), calculated by DHCFP, is the sum of each hospital's inpatient reasonable costs and actual outpatient costs divided by the hospital's GPSR. To determine reasonable inpatient costs, the Division compares the hospital's actual inpatient cost per discharge (adjusted for

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case-mix and wage variations) to a statewide efficiency standard. The efficiency standard is the statewide weighted mean cost per discharge. If the hospital's cost per discharge exceeds this standard, the hospital's costs are capped at the standard. If the hospital's cost per discharge is below the standard, the hospital's actual costs are allowed. The allowable amounts are then readjusted for case-mix and wage area and multiplied by discharges. Data for this calculation comes from the DHCFP-403 Cost Report.

- b. Total Low Income Patient Care Costs are trended by 7.6% from the base period to the prior fiscal year, and by 7.6% from the prior fiscal year to the current fiscal year. This trend is the average growth rate for FY99-FY03 weighted inpatient and outpatient costs.
- iii. DHCFP calculates the percentage of Total Low Income Patient Care Costs for the current fiscal year which each hospital will receive as its Total Payment for Low Income Patients for the current fiscal year.
 1. State-defined Disproportionate Share Hospitals
 - a. DHCFP determines the percentage of each hospital's gross patient service revenue (GPSR) that is attributable to Medicare, Medicaid, other governmental payers, and free care.
 - i. Data for this calculation comes from the DHCFP-403 Cost Report and the UC-Form filing. For the purposes of this calculation, Medicare managed care GPSR is included as Medicare GPSR, and Medicaid managed care GPSR as Medicaid GPSR.
 - ii. If this percentage is greater than or equal to 63%, the hospital qualifies as a state-defined Disproportionate Share Hospital.
 - b. DHCFP calculates each state-defined Disproportionate Share Hospital's share of all statewide Total Low Income Patient Care Costs for the fiscal year three years prior, and ranks the hospitals accordingly.
 - i. The two state-defined Disproportionate Share Hospitals with the highest percentage of statewide Total Low Income Patient Care Costs in the fiscal year three years prior receive 85% of their Total Payment for Low

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- Income Patients for the current fiscal year.
 - ii. The fourteen state-defined Disproportionate Share Hospitals with the next highest percentage of statewide Total Low Income Patient Care Costs in the fiscal year three years prior receive 88% of their Total Payment for Low Income Patients for the current fiscal year.
 - 2. Other hospitals
 - a. Freestanding pediatric hospitals will receive \$5.79 million.
 - b. DHCFP divides the remaining allocation by the sum of the Total Low Income Patient Care Costs for the current fiscal year for all remaining hospitals. The Total Payment for Low Income Patients is this percentage multiplied by each remaining hospital's Total Low Income Patient Care Costs.
- 4. **Safety Net Care Payments for Pediatric Specialty Hospitals and Hospitals with Pediatric Specialty Units (114.1 CMR 36.07)**
 - a. Description
 - i. Safety Net Care Payments for Pediatric Specialty Hospitals and Hospitals with Pediatric Specialty Units are for hospitals which serve children with Medicaid.
 - b. Eligibility
 - i. All pediatric specialty hospitals and hospitals with pediatric specialty units are eligible for this payment.
 - 1. Pediatric Specialty Hospitals are defined as hospitals that limit admissions primarily to children and qualify as exempt from Medicare prospective payment system regulations
 - 2. Hospitals with Pediatric Specialty Units are defined as acute hospitals which maintain level 1 burn and trauma centers for pediatrics, or in which the ratio of licensed pediatric beds to total licensed beds as of July 1, 1994 exceeded 0.20, unless located in a facility already designated as a specialty hospital.
 - ii. Based on the eligibility criteria, Massachusetts General Hospital, New England Medical Center, and Children's Hospital are the only hospitals that qualify for this payment.
 - c. Calculation
 - i. The General Court makes an appropriation for this payment.
 - ii. For each eligible hospital, DHCFP calculates the ratio of Medicaid pediatric days to the sum of Medicaid pediatric days for all eligible hospitals.

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- iii. This ratio is multiplied by the total appropriation for this payment, and the result is each hospital's payment.

5. Basic Safety Net Care Payment (114.1 CMR 36.07)

a. Description

- i. The Basic Safety Net Care Payment is for acute hospitals that have a disproportionate amount of inpatient Medicaid days or low-income utilization.

b. Eligibility

i. Medicaid utilization method

- 1. DHCFP calculates the threshold Medicaid inpatient utilization rate.
 - a. The threshold Medicaid inpatient utilization rate is the sum of Medicaid inpatient days for all acute hospitals in the state, divided by the sum of all inpatient days for all acute hospitals in the state, plus the standard deviation of this number.
- 2. DHCFP calculates each hospital's Medicaid inpatient utilization rate
 - a. This is each hospital's total number of Medicaid inpatient days, divided by its total inpatient days.
- 3. If a hospital's Medicaid inpatient utilization rate exceeds the statewide Medicaid inpatient utilization rate, it qualifies for the Basic Safety Net Care Payment.

ii. Low-income utilization rate method

- 1. DHCFP calculates each hospital's low-income utilization rate
 - a. The low-income utilization rate is the sum of
 - i. The hospital's Medicaid and subsidy share of gross revenues: gross Medicaid revenues plus state and local government cash subsidies, divided by the hospital's total revenues plus state and local cash subsidies, and;
 - ii. The hospital's free care percentage of total inpatient charges: inpatient free care charges minus the inpatient share of state and local cash subsidies, divided by total inpatient charges.
- 2. If a hospital's low-income utilization rate exceeds 25%, it qualifies for the Basic Safety Net Care Payment.
- iii. Based on the eligibility criteria, most acute hospitals are eligible for this payment.

c. Calculation

- i. EOHHS allocates \$200,000 for this payment.

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- ii. Medicaid utilization method
 1. DHCFP divides each hospital's Medicaid inpatient utilization rate by the threshold Medicaid inpatient utilization rate – this is the Basic Medicaid ratio for these hospitals.
 - iii. Low-income utilization rate method
 1. For hospitals that do not meet the criteria of the Medicaid utilization method, DHCFP divides each hospital's low-income utilization rate by 25% - this is the Basic Medicaid ratio for these hospitals.
 - iv. DHCFP divides the amount of funds allocated for the Basic Safety Net Care payment by the sum of all Basic Medicaid ratios. This is the minimum payment.
 - v. DHCFP then multiplies the minimum payment by the Basic Medicaid ratio for each hospital. This is each hospital's Basic Safety Net Care payment.
6. **Cost determination for certified public expenditures**
- a. Placeholder for CMS-approved CPE methodology for acute hospitals

B. **Non-Acute Hospital Payment Methodologies.**

MassHealth will assist Hospitals that carry a financial burden of caring for uninsured and publicly insured persons of the Commonwealth. In accordance with the terms and conditions of the Commonwealth's section 1115 demonstration governing Safety Net Care, and subject to compliance with all applicable federal requirements, MassHealth will make an additional payment above the Title XIX state plan rate to Non-Acute Hospitals that qualify for such payment under any one or more of the classifications listed below. The following describes how Hospitals will qualify for each type of Safety Net Care payments and the methodology for calculating those payments.

All Safety Net Care payments are subject to the availability of federal financial participation.

1. **Safety Net Care Payments for Special Population State-Owned Non-Acute Hospitals Operated by the Department of Public Health.**
The Commonwealth shall determine a Safety Net Care payment for all eligible Special Population State-Owned Non-Acute Hospitals, using the data and methodology described below.

The Commonwealth shall use the DHCFP-403 report for the fiscal year two years prior to the fiscal year of the calculation of the Safety Net Care payment to determine the cost, free care, charge, patient day, and net

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revenue amounts. If the DHCFP-403 report is not available, the Commonwealth shall use the most recent available previous DHCFP-403 report to estimate these variables.

In order to qualify for this payment, a State-Owned Non-Acute Hospital must:

- Be owned or operated by the Massachusetts Department of Public Health;
- Provide treatment to people with AIDS, tuberculosis patients, the medically needy homeless, multiply handicapped pediatric patients and patients with combined medical and psychiatric needs; and
- Participate as a Non-Acute Hospital provider in the MassHealth program.

For each state-owned special population Non-Acute Hospital that qualifies for the payment in this paragraph, the payment amount shall be calculated as follows:

- First, determine the annual cost and revenue of providing hospital services to Medicaid-eligible and uninsured individuals using the data sources describe in this paragraph;
- Second, subtract the annual revenue from the annual costs to determine the uncompensated costs of providing services to Medicaid-eligible and uninsured individuals;
- Calculate adjustments to account for any significant changes in utilization, cost trends, or payment methods. Inflation will be considered by applying a composite index comprised of two cost categories: labor and non-labor. The categories are weighted according to the weights used by CMS for PPS-excluded hospitals. The inflation proxy for the labor cost category is the Massachusetts Consumer Price Index (optimistic forecast). The inflation proxy for the non-labor cost category is the non-labor portion of the CMS market basket for hospitals;
- The payment amount shall be computed up to 100% of the uncompensated costs of providing hospital services to Medicaid-eligible and uninsured individuals.

Based on the eligibility criteria, Shattuck Hospital, Tewksbury Hospital, Massachusetts Hospital School, and Western Massachusetts Hospital are the only hospitals eligible for this payment.

2. **Safety Net Care Payments for State-Owned Non-Acute Hospitals Operated by the Department of Mental Health.**

The Commonwealth shall determine a Safety Net Care payment for all eligible State-Owned Non-Acute Hospitals operated by the Department of Mental Health, using the data and methodology described below.

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The Commonwealth shall use the DHCFP-403 report for the fiscal year two years prior to the fiscal year of the calculation of the Safety Net Care payment to determine the cost, free care, charge, patient day, and net revenue amounts. If said DHCFP-403 report is not available, the Commonwealth shall use the most recent available previous DHCFP-403 report to estimate these variables.

In order to be eligible for the Safety Net Care payment, a State-Owned Non-Acute Hospital operated by the Department of Mental Health must:

- Be owned or operated by the Massachusetts Department of Mental Health;
- Specialize in providing psychiatric/psychological care and treatment; and
- Participate as a Non-Acute Hospital provider in the MassHealth program.

For each State-Owned special population Non-Acute Hospital determined eligible for the Safety Net Care payment under this section, the payment amount shall be calculated as follows:

- First, determine the annual cost and revenue of providing hospital services to Medicaid-eligible and uninsured individuals using the data sources set forth in this Section;
- Second, subtract the annual revenue from the annual costs to determine the uncompensated costs of providing services to Medicaid-eligible and uninsured individuals;
- Calculate adjustments to account for any significant changes in utilization, cost trends, or payment methods. Inflation will be considered by applying a composite index comprised of two cost categories: labor and non-labor. The categories are weighted according to the weights used by CMS for PPS-excluded hospitals. The inflation proxy for the labor cost category is the Massachusetts Consumer Price Index (optimistic forecast). The inflation proxy for the non-labor cost category is the non-labor portion of the CMS market basket for hospitals;
- The Safety Net Care payment amount shall be computed up to 100% of the uncompensated costs of providing hospital services to Medicaid-eligible and uninsured individuals.

Based on the eligibility criteria, the following facilities are eligible for this payment: Cape Cod and Islands Mental Health Center, Corrigan Mental Health Center, Lindemann Mental Health Center, Quincy Mental Health Center, SC Fuller Mental Health Center, Taunton State Hospital, Westborough State Hospital, and Worcester State Hospital.

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3. Safety Net Care Payments for Pediatric Non-Acute Hospitals

The Commonwealth shall use the DHCFP-403 report for the fiscal year two years prior to the fiscal year of the calculation of the Safety Net Care payment to determine the cost, free care, charge, patient day, and net revenue amounts. If said DHCFP-403 report is not available, the Commonwealth shall use the most recent available previous DHCFP-403 report to estimate these variables.

In order to be eligible for the Safety Net Care payment, a Non-Acute Hospital must limit admissions primarily to children and participate as a Non-Acute Hospital provider in the MassHealth program.

For each special population Non-Acute Hospital determined eligible for the Safety Net Care payment under this section, the payment amount shall be calculated as follows:

- First, calculate the ratio of MassHealth pediatric days to the total MassHealth pediatric days for all hospitals that limit admissions primarily to children;
- Second, multiply the above ratio by the total allocation determined annually by and specified in regulations of the Division of Health Care Finance and Policy at 114.3 CMR 36.07(7)(c) to determine the individual payment amount for each eligible hospital; and,
- The Safety Net Care payment amount shall be computed up to 100% of the uncompensated costs of providing hospital services to Medicaid-eligible and uninsured individuals.

Based on the eligibility criteria, Franciscan Hospital for Children is the only hospital eligible for this payment.

IV. SNCP Payment Methodologies for State Fiscal Year 2007

The following payment methodologies are new payment methodologies for SFY 2007. The SFY 2006 acute and non-acute hospital payment methodologies described in Section III will be carried over to SFY 2007, with the exception of the Basic Safety Net Care Payment, which will no longer be made in SFY 2007. SNCP payment methodologies for SFY 2008 will be amended as needed.

A. Section 122 of Chapter 58 Safety Net Health System Payments

The Executive Office of Health and Human Services will make supplemental payments to the two publicly operated or public-service state-defined disproportionate share hospitals with the highest relative volume of uncompensated care costs in hospital fiscal year 2007. As described in Section 122 of Chapter 58 of the Acts of 2006, this payment will not exceed \$200 million for total unreimbursed

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free care and Medicaid services, including Medicaid managed care services, and the operation of the respective safety net health care systems. The \$200 million will be decreased by \$20 million dollars in SFY 2008 and in SFY 2009. Boston Medical Center and Cambridge Health Alliance are the only hospitals eligible for this payment.

B. Commonwealth Care Health Insurance Program Premium Assistance Payment Methodologies

Income-based sliding scale premium contribution payment to managed care organizations licensed under MGL c. 175 by the Massachusetts Division of Insurance by July 1, 2007 for individuals with household income that does not exceed 300% FPL according to a schedule to be developed by the Commonwealth Care Health Insurance Connector Authority. Further detail on the exact payment methodology will be submitted not later than December 31, 2006.

C. Institution for Mental Disease Payment Methodologies

The following sections describe the methods and standards utilized by the Commonwealth of Massachusetts to establish Safety Net Care rates of payment for services rendered by Institutions for Mental Diseases to inpatients who are otherwise eligible for MassHealth benefits but who are age 21 or over, under age 65 and not enrolled in a MassHealth managed care organization.

Safety Net Care payments are limited to inpatient care in Institutions for Mental Diseases of persons who are otherwise eligible for MassHealth benefits but who are age 21 or over and under age 65. Safety Net Care rates of payment to Institutions for Mental Diseases will be described in a written contract with each Institution for Mental Disease. Safety Net Care payment for inpatient services in an Institution for Mental Diseases shall be paid up to a maximum of 30 consecutive days per admission and up to a maximum of 60 inpatient days per calendar year per inpatient.

There are no Safety Net Care payments for outpatient services; payment for outpatient services are not affected by the federal IMD exclusion; therefore, outpatient service payments for persons eligible for Title XIX coverage will continue to be governed by the Commonwealth's Title XIX state plan. In Massachusetts, most Institutions for Mental Diseases are privately owned and operated.

1. Safety Net Care Payment for Inpatient Services

The Commonwealth has established a Safety Net Care Inpatient Per Diem Rate for Institutions for Mental Diseases, covering services provided to inpatients who would otherwise be eligible for MassHealth benefits (but for the IMD exclusion) and who are not enrolled in a MassHealth managed care organization. The Safety Net Care Inpatient Per Diem Rate will consist of two components:

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- A Statewide Standard Per Diem Component; and
 - A Transitional Add-on Component.
- a. The Statewide Standard Per Diem Component is derived from cost report information submitted by Institutions for Mental Diseases. The Commonwealth will calculate base period standards using the HCFP-403 cost reports. Standards will be computed in four categories, the sum of which will be the Statewide Standard Per Diem Component:
- Standard for Inpatient Direct Routine Costs;
 - Standard for Inpatient Direct Ancillary Costs;
 - Standard for Inpatient Overhead Costs; and
 - Standard for Inpatient Capital.

The base period cost information will be updated using the appropriate MassHealth acute inpatient hospital update factors (SPAD inflation factors) to generate the Statewide Standard Per Diem Component.

- b. Transitional Add on Component, which shall mitigate any significant differences between the Statewide Standard Per Diem Component and the rates that were payable in prior years to Institutions for Mental Diseases years under the Commonwealth's then-existing 1115 Demonstration.

2. **Safety Net Care Payment for IMD Administrative Days**

The Commonwealth will pay for Administrative Days of inpatients who would otherwise be eligible for MassHealth benefits (but for the IMD exclusion) and who are not enrolled in a MassHealth managed care organization by using a Safety Net Care Administrative Day Per Diem Rate (AD Rate). The term 'administrative days' refers to days of IMD inpatient hospitalization on which the eligible individual's care needs could be met in a less intensive setting, and on which this individual is clinically ready for discharge, but remains in the IMD because an appropriate institutional or non-institutional setting is not readily available. The Safety Net Care AD Rate will be an all-inclusive daily rate paid for each Administrative Day. The AD Rate will be based on the MassHealth acute hospital inpatient administrative day rate.

3. **Safety Net Care Payments for Inpatient Services at Community-Based Detoxification Centers**

Safety Net Care payments to community-based detoxification centers shall be made based upon a fixed fee schedule established by the Division of Health Care Finance and Policy, at 114.3 CMR 46.04, in accordance with its duly promulgated regulation (incorporated below).

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Rate schedule for community-based detoxification centers (114.3 CMR 46.04)

Code	Rate	Description
Inpatient Services		
H0010	\$109.10	Alcohol and/or drug services; sub-acute detoxification (residential addiction program inpatient); (Level III-B, per day)
H0010-52	\$72.43	Alcohol and/or drug services; sub-acute detoxification (residential addiction program inpatient) (reduced services); (Level III-C, per day)
H0011	\$198.00	Alcohol and/or drug services; acute detoxification (residential addiction program inpatient); (Level III-A, per day)
Residential Services		
H2034	\$55.00	Alcohol and/or drug abuse halfway house services, per diem (residential rehabilitation)
Opioid Treatment Services		
<u>Medical Services Visit</u>		
H0020	\$10.21	Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program); (dose only visit)
<u>Counseling</u>		
H0020-TF	\$27.59	Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program); (intermediate level of care); (individual, per 30 minute unit, two units maximum per session)
H0020-HR	\$33.12	Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program); (family/couple with client present, per 30 minute unit, two units maximum per session)
H0020-HQ	\$10.74	Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program); (group setting); (per 45 minute unit, two units maximum per session)
Ambulatory Services		
<u>Outpatient Counseling</u>		
90882-HF	\$27.59	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions; (substance abuse program) (per 30 minute unit, two units maximum per session) (case consultation)
H0001	\$13.79	Alcohol and/or drug assessment (per 15 minute unit, 4 units maximum per session)
H0004	\$13.79	Behavioral health counseling and therapy, per 15 minutes; (individual counseling, four units maximum per session)
H0005	\$10.74	Alcohol and/or drug services; group counseling by a clinician; (per 45 minute unit, two units maximum per session)

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Code	Rate	Description
T1006	\$33.12	Alcohol and/or substance abuse services; family/couple counseling (per 30 minute unit, two units maximum per session)
<u>Driver Alcohol Education</u>		
H0001-H9	\$13.79	Alcohol and/or drug assessment (court-ordered) (per 15 minute unit, 6 units maximum per session)
H0004-H9	\$13.79	Behavioral health counseling and therapy, per 15 minutes (court-ordered); (individual , 6 units maximum per session)
H0005-H9	\$7.16	Alcohol and/or drug services; group counseling by a clinician (court-ordered); (per 30 minute unit, four units maximum per session)
Day Treatment		
H2012-HF	\$14.91	Behavioral health day treatment, per hour (substance abuse program); (4 hours per day)
Services for Pregnant/Postpartum Recipients		
<u>Inpatient Services</u>		
H0011-HD	\$247.95	Alcohol and/or drug services; acute detoxification (residential addition program inpatient) (pregnant/parenting women's program); (Level III A, per day)
<u>Outpatient Services</u>		
H0004-HD	\$13.79	Behavioral health counseling and therapy, per 15 minutes; (pregnant/parent women's program) (individual counseling, four units maximum per session)
H0005-HD	\$10.74	Alcohol and/or drug services; group counseling by a clinician; (pregnant/parenting women's program); (per 45 minute unit, two units maximum per session)
H0006-HD	\$8.00	Alcohol and/or drug services; case management (pregnant/parenting women's program); (per 15 minute unit, four units maximum per day)
T1006-HD	\$33.12	Alcohol and/or substance abuse services; family/couple counseling (pregnant/parenting women's program); (per 30 minute unit, two units maximum)
<u>Day Treatment</u>		
H1005	\$55.17	Prenatal care, at-risk enhanced service package (includes H1001-H1004) (prenatal care, at risk enhanced service, antepartum management, care coordination, education, follow-up home visit) (individual counseling, one hour unit, one unit maximum per day)
H1005-HQ	\$59.64	Prenatal care, at-risk enhanced service package (includes H1001-H1004) (prenatal care, at risk enhanced service, antepartum management, care coordination, education, follow-up home visit) (group setting); (per four hour unit, one unit maximum per day)

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Exhibit A - Detailed Fund Structure SFY 2007

	Commonwealth Care Trust Fund	Uncompensated Care Trust Fund (FFY 2007) Health Safety Net Trust Fund (FFY 2008)	Medical Assistance Trust Fund
Source of funds	General Fund transfers Fair share employer contributions Free rider surcharges Individual tax penalties Transfers from Health Safety Net Trust Fund	General Fund transfers Hospital assessment Insurer surcharge Transfers from Commonwealth Care Trust Fund	General Fund transfers
Permissible uses	Programs designed to increase health coverage, including a program of subsidized health insurance Pay for performance for Medicaid providers Supplemental payments to BMC/CHA	Free care payments to hospitals Relevant administrative costs	Supplemental payments to BMC, CHA, and UMMHC
Conditions of spending	Available revenue	Available revenue	Available FFP Budget neutrality
Transfer authority	To/from Uncompensated Care Trust Fund (Health Safety Net Trust Fund)	To/from Commonwealth Care Trust Fund	None
Administrative authority	Secretary of Administration & Finance	Division of Health Care Finance and Policy (FFY 2007) Health Safety Net Office (FFY 2008)	Secretary of EOHHS
Unspent balances	Remain in fund	Revert to Commonwealth Care Trust Fund	Remain in fund
Funds before transfer	\$680M	\$320M	\$251M
Funds after transfer	\$450M	\$550M	\$251M

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Claims from SNCP	\$360M	\$244M	\$104M
Other Medicaid	\$90M	\$306M	\$147M

Cross-Walk to the Safety Net Care Pool	Amount (\$millions)
Safety Net Care Pool claims listed above from CCTF, UCTF, MATF	\$708
Other claims from the safety net care pool	
Designated state healthcare programs	\$385
DMH and DPH non-acute state hospital CPEs	\$130
Acute hospital CPEs	\$86
Minor DSH - pediatric specialty, high public payer and basic	\$22
Institutes of mental disease	\$14
<i>Sub-total</i>	<i>\$636</i>
Total claims from the Safety Net Care Pool	\$1,344